**General Information**

*\*Write name AND address as it appears on insurance card.*

Student’s Name: DOB: Age:

How did you hear about Every Day Counts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: Mailing Address (if different):

 Male Referred By: Diagnosing Dr:

 Female Primary Diagnosis: Secondary Diagnosis:

 Date diagnosis was given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: white, black, Hispanic, Asian, other SSN:

**Guardian Information**

Guardian Name: Relationship: Phone number: Address if different from above: Email address: Do you live with patient: y / n

Place of employment: Address: Phone Number: Contact: Guardian Name: Relationship: Phone number: Address if different from above: Email address: Do you live with patient: y / n

Place of employment: Address:

Phone Number: Contact:

**Siblings**

Name: Age: Name: Age: Name: Age: Name Age:

**Services Being Requested Check all ABA Services you are inquiring about for your student:**

 home based \_\_school based

 center based \_\_\_parent coaching

**Schedule Availability:**

*Write n/a if unavailable*

Monday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuesday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wednesday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thursday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Friday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Saturday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Primary: Insurance ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of policy holder: Bayou Health Provider: y / n

Policy holders DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary: Insurance ID Number: Name of policy holder: Bayou Health Provider: y / n

**Emergency Contact**

*Other than guardians listed above*

Name: Relationship: Address: Phone Number: Authorized to pick up: y / n

Name: Relationship: Address: Phone Number: Authorized to pick up: y / n

Name: Relationship: Address: Phone Number: Authorized to pick up: y / n

**Authorized Pick-Up (if center setting)**

*List if not listed above*

Name: Relationship:

Phone Number:

Name: Relationship:

Phone Number:

Name: Relationship:

Phone Number:

Name: Relationship:

Phone Number:

**Physicians**

Primary Physician: Group:

Phone number: Permission to contact? y / n

Diagnosing Dr: Group:

Phone number: Permission to contact? y / n

Specialist: Group:

Phone number: Permission to contact? y / n

Specialist: Group:

Phone number: Permission to contact? y / n

**Other Therapies/Services**

Include how often, dates and if currently receiving

Speech: \_\_\_y \_\_\_ n

Name of Provider: \_\_\_\_\_\_\_\_Group:

Length of sessions: # days/week: Effective: \_\_\_y \_\_\_n

Begin date: - End date or Current \_\_\_y \_\_\_n

Occupational Therapy: \_\_\_y \_\_\_ n

Name of Provider:\_\_\_\_\_\_\_\_\_ Group:

Length of sessions: # days/week: Effective: \_\_\_y \_\_\_n

 Begin date: - End date or Current \_\_\_y \_\_\_n

Other: \_\_\_y \_\_\_ n

Name of Provider:\_\_\_\_\_\_\_\_\_ Group:

Length of sessions: # days/week: Effective: \_\_\_y \_\_\_n

 Begin date: - End date or Current \_\_\_y \_\_\_n

 **Education**

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade attended: \_\_\_\_\_\_ Currently enrolled: y / n

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade attended: \_\_\_\_\_\_ Currently enrolled: y / n

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade attended: \_\_\_\_\_\_ Currently enrolled: y / n

Other Services provided at school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If other services are provided, who are they provided by? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current IEP? \_\_\_ yes \_\_\_ no If yes, attach to intake.

 **Past ABA Services**

Past ABA Received? \_\_\_ yes \_\_\_no If yes, received by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of services: Began End

Reason for discontinuing? (If more than 1 past provider- list them below with dates & name of providers)

Reason for seeking out Every Day Counts for services:

**Allergies**

List all allergies: Treatment for allergies listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosing Dr:

**Current Medications**

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose: \_\_\_\_\_\_Frequency: \_\_\_\_\_ Effective: y / n

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose: \_\_\_\_\_\_Frequency: \_\_\_\_\_ Effective: y / n

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose: \_\_\_\_\_\_Frequency: \_\_\_\_\_ Effective: y / n

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose: \_\_\_\_\_\_Frequency: \_\_\_\_\_ Effective: y / n

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose: \_\_\_\_\_\_Frequency: \_\_\_\_\_ Effective: y / n

# **Behaviors of Concern**

 *List the top behaviors of concern you have regarding your student*

|  |
| --- |
| 1. Describe the behavior: How often does it occur?How long does it last?Rate severity: Circle one- mild / moderate / severe(mild = disruptive but little risk of injury; moderate= property damage or minor injury; severe= significant threat to health or safety) |

|  |
| --- |
| 2. Describe the behavior: How often does it occur?How long does it last?Rate severity: Circle one- mild / moderate / severe(mild = disruptive but little risk of injury; moderate= property damage or minor injury; severe= significant threat to health or safety) |

|  |
| --- |
| 3. Describe the behavior: How often does it occur?How long does it last?Rate severity: Circle one- mild / moderate / severe(mild = disruptive but little risk of injury; moderate= property damage or minor injury; severe= significant threat to health or safety) |

What situations are these behaviors MOST likely to occur? (Days/times/setting/activities/persons present)

|  |
| --- |
|  |

What typically happens right BEFORE problem behavior occurs?

|  |
| --- |
|  |

What typically happens right AFTER problem behavior occurs?

|  |
| --- |
|  |

What current treatments are being implemented for the behaviors listed above? Are these treatments successful?

|  |
| --- |
|  |

What treatments have been implemented in the past?

|  |
| --- |
|  |

What motivates or interests your student? What makes them happy?

|  |
| --- |
|  |

What else would you like us to know about your student?

|  |
| --- |
|  |

# **Skills Assessment**

*Check the most appropriate that describes your student.*

|  |  |  |  |
| --- | --- | --- | --- |
| Skill | Always | Sometimes | Never |
| Does your student speak freely and easily? |  |  |  |
| Does your student use sentences to get their needs or wants met? |  |  |  |
| Does your student communicate with gestures, sign language, or communication device? |  |  |  |
| Does your student ask for at least 5 items on a daily basis? |  |  |  |
| Skill | Always | Sometimes | Never |
| Does your student say words or sounds you say after you say them (echo you)? |  |  |  |
| Does your student answer questions correctly when asked (if the answer is known)? |  |  |  |
| Does your student follow directions and routines out of context? |  |  |  |
| If you show your student how to do something, will they do it after you show them? (imitation) |  |  |  |
| Does your student follow simple motor commands (ie. they are told to clap (without being shown) and they clap)? |  |  |  |
| Does your student make eye contact? |  |  |  |
| Does your student look when someone walks in a room? |  |  |  |
| Does your student engage in age appropriate activities? |  |  |  |
| Does your student have a particular topic they could engage in all day if you would let them? |  |  |  |
| Is your student free of urine accidents? |  |  |  |
| Is your student free of bowel movement accidents? |  |  |  |
| Does your student wear underwear? |  |  |  |
| Does your student dress by themselves? |  |  |  |
| Does your student have a sense of danger? |  |  |  |

# Parent/Guardian Signature: Date:

Reviewed By (Staff Signature): Date: