Pacheco ABA Service

and Behavioral Consulting

Client Intake Packet

Service Delivery Promise

Attendances

- PACHECO ABA will do its best to maintain reliable staffing.
- The Company will do its best to maintain the agreed time frame per company policy.
- The parent/guardian will have the client ready for the session and be available during the scheduled session time.
- The parent/ Guardian will keep scheduling with no more than 10% cancelled time per quarter.

Your Clinician will discuss cancellation if your Child gets above 10% cancellation per quarter. Excessive cancellation will result in client discharge from PACHECO ABA services.

Child's Name: DATE: _____

Date of Birth:

Clinician Sign: DATE: _____

Parent/Guardian Sign: DATE:

Print Name:

PRIVATE TRANSPORTATION RELEASE CONSENT FORM

At times it becomes necessary to use private vehicles to transport students to and from program activities. Pacheco ABA requires that the guardian to sign a Private Transportation Release Consent Form that appears below: By signing this form, I hereby release Pacheco ABA, as well as its clinicians or employees from all liability or damages for all injuries arising while traveling to this activity via private transportation. Our employees will follow a strict rule set when transporting our students with safety in mind. Students and staff are required to always wear seat belts. Staff are required to follow the rules of the road, and if an injury does happen while breaking the law, they are deemed liable. Please sign below if you agree to allow our clinicians to transport your child to and from program activities or school.

Guardian Signature: Date: _____

Witness: Date:

Sincerely,

Steven Pacheco MS, LABA

Pacheco ABA Service and Behavioral Consulting

LLC Pacheco.aba@outlook.com

Pacheco ABA Service and Behavior Consulting LLC

AUTHORIZATION TO RELEASE INFORMATION

Expires: _____

Patient Name: _DOB: __

Street Address:

_____

City/State: _____ _____

Zip:

I understand this release is voluntary and applies to all programs and services operated under the auspices of Pacheco ABA Service and Behavior Consulting LLC.

I hereby authorize Pacheco ABA Service and Behavior Consulting LLC to (check all that apply):

☐ **Exchange information with** ☐ Release information to ☐ Obtain information from

the following Organization/Individual regarding the above-named patient:

Name of Organization/Individual: _____

Address:

_____

City:

____

State: _Zip: ___ Phone: _____

Description of information to be exchanged / released / obtained (select all that apply):

☐ Education records

☐ Evaluation/assessment/eligibility records

☐ Medical records

☐ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies) ***This information is to be used for diagnostic, treatment planning and continuity of care purposes only.**

Signature of Parent or Legal Guardian: _____ Date: _____

Print Name of Person signing form:

Relationship to Patient:

Licensed Clinician:

Pacheco ABA Service and Behavior Consulting LLC

AUTHORIZATION TO RELEASE INFORMATION

Expires: _____

Patient Name: _DOB: __

Street Address:

_____

City/State: _____ _____

Zip:

I understand this release is voluntary and applies to all programs and services operated under the auspices of Pacheco ABA Service and Behavior Consulting LLC.

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☐ Education records

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☐ Medical records

☐ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies) ***This information is to be used for diagnostic, treatment planning and continuity of care purposes only.**

Signature of Parent or Legal Guardian: _____ Date: _____

Print Name of Person signing form:

Relationship to Patient:

Licensed Clinician:

Pacheco ABA Service and Behavior Consulting LLC

Use Of Photographs and Video Release

Patient Name: _____DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Pacheco ABA Service and Behavior Consulting LLC.

Pacheco ABA provides many attempts for community and social outings and would love to document them with company pictures and videos of your children having fun and learning. By Checking off the boxes below, you authorize Pacheco ABA to post pictures and videos to our company website and social media.

I hereby authorize Pacheco ABA Service and Behavior Consulting LLC to (check all that apply):

☐ **Use Of still photography** ☐ **Use of Videos**

☐ **Do not authorize**

***This information is to be used for company use only:**

Signature of Parent or Legal Guardian: _____Date: _____

Print Name of Person signing form: _____

COVID 19 Protocols for Parents Cancelling sessions:

If you or anyone in your household has experienced these symptoms within the last 48 hours, please call your clinician to reschedule your child's session.

Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing.
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

FOR EMPLOYEES: You MUST inform your supervisor if you:

- Have any of the above symptoms, received a confirmed positive COVID-19 test result, have been diagnosed with COVID-19 by a licensed healthcare provider, Experience new loss of taste and/or smell with no other explanation; or Experience both fever (≥100.4° F) and new unexplained cough associated with shortness of breath.

***If you attend a session and notice any symptoms above by the family, it is ok if you politely end session and notify your supervisor to contact the family for future scheduling.

Signature DATE

Thank you for your continued help to keep everyone safe during this time. If you have any questions or concerns, please feel free to call or email me at any time.

Steven Pacheco Owner/LABA

Office Phone: 508-974-4760

Email: Steven@pachecoaba.com

Client:

DOB:

Client must be picked up by someone on this list verified by guardian.

No Exceptions!

Please provide name and phone number

1. _____

2. _____

3. _____

Parent Signature: _____

Date: _____

Late Policy

Pacheco ABA late policy as well as late pickups.

Please be advised that everyone is approved for allotted hours by insurance based on their specific case and needs. Our company does not cover or provide outside of the approved allotted hours for any individual. Please note that your child cannot be taken earlier than their set appointment time UNLESS we are told prior. If you are going to arrive any later than 15 minutes after the scheduled start time you will need to contact us. If we do not hear from you within those 15 minutes, taking the client in will be under management's discretion. Multiple instances of being late/no call no show can lead to your child being discharged.

I, _____agree and confirm that I have read the policy above. I agree to abide by the late policy and know that my child could be discharged according to the offense. All late offenses will be documented.

Parent/Guardian Signature _____ **Date** _____

Intake form

Client Demographics:

Name: _____

Address: _____

Phone Number: (_____) _____-_____

Age_____ **Date of Birth:** / /

Current Diagnosis:	**Date of Diagnosis:**
Diagnosed By:	**Age at Diagnosis:**

Numbers of Hours for Services:

Availability: Times and Days

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Parents and/or Guardians:

Mothers Name:	Fathers Name:
Home Number:	Home Number:
Mobile Number:	Mobile Number:
Work Number:	Work Number:
Email Address:	Email Address:

Are parents married_____Divorced_____Separated_____

If divorced, who has custody of minor What days?

Please list any stepparents: _____

List any others living in the home:

Name	**Age**	**Relationship**

Are there any people who have a significant role on how this child is raised?

Family Psychological History:

Is there a history in your immediate or in the mother/father's extended family, of the following, and if so, what?

Yes	No		Who?
		Autism Spectrum Disorders	
		Learning Problem/ Disabilities	
		ADHD-ADD-Attention Problems	
		Depression or bipolar disorder	
		Behavior Problems in School	
		Anxiety Disorders (OCD, Phobias, etc.)	
		Psychosis/ Schizophrenia	
		Substance Abuse/Dependence	
		Other Mental Health Concerns	

School/Childcare Center:

Name of School/ Center:
Principal/Contact Person:
Teachers Name:
Phone Contact:
Email:
Address:

Primary Insurance:

Subscribers Name:

Subscribers Employer:
Carrier:
Group Number:
Phone Number:
Case Manager:
ID #
Fax#
Claims Address

Primary Care Provider

Name:	Phone:
Address:	City:
State/Zip Code:	Contact #:

1. Please indicate if your child is experiencing any of the following: Yes/No **Problems with eating/Prepare**

- Meals/snacks _____
- Pour drinks _____
- Clean after eating _____
- Eats out appropriately with family _____

Grooming/Dressing

- Pulls pants up/down _____
- Shoes on/off _____

- Ties shoes _____
- Puts Shirts on/off _____

Hygiene

- Hand washing _____
- Teeth brushing _____
- Blows Nose _____
- Bathing _____ **Toileting**
- Urinates independently _____
- Bowel movements independently _____

Safety and Health

- Follows playground rules/turn taking _____
- Informs parent when sick/hurt _____
- Takes medication independently _____
- Reports emergencies _____
- Avoids hazards Electricity/poison/matches/common household _____ **Assists in care taking**
- Helps classmates/siblings clean _____
- Shares toys or materials _____
- Gets something for the parent from next room _____
- Picks up toys _____
- Puts dirty clothes away _____

Budgeting and planning/scheduling

- Saves money in a piggy bank _____
- Knows the value of money _____
- Uses money to purchase goods _____

Travel

- Walks next to/holds hand of caregiver _____
- Crosses street appropriately _____
- Looks both ways _____
- Stops at the curb _____
- Walks or rides bus appropriately _____

Community Safety

- Does talk to strangers nor accept things from strangers _____
- Stays with parent while shopping _____

Behaviors

- Aggression: Hits, kicks, pinches, punches, biting _____
- Elopes -leave an area/caregiver without permission _____
- Flopping -Falling to the floor _____

General problems

- Problems keeping friends _____
- Problems going to sleep _____
- Problems controlling temper _____ _____
- Problems sleeping through the night _____
- Trouble waking up _____
- Fatigue/Tiredness through the days _____ _____
- Bed Wetting _____ _____
- Problems with authority _____
- Anxiety _____ _____
- Unmotivated _____ _____
- Stress from conflict between parents _____
- History of Abuse _____ _____

- School Concentration Difficulties _____
- Sadness or Depression _____

1. List any operations, serious illnesses, injuries, hospitalizations, allergies, ear infections, or other special conditions:

_____

_____

_____

_____

_____

With which hand does the child write with right_____left_____both_____

Does the individual have any visual problems: _____

Does the child have any hearing problems: _____

Does your child's teacher have concerns about him/her at school?

_____

Does your child engage in extracurricular activities?

_____

Please list 5 things you would like your child to do (MORE OR LESS) in order of priority to you. For example, instead of saying "I want my child to be more responsible" translate that into actual behaviors such as doing household chores.

Like the Child to do more often **Like the child to do less often**

1. _____ _____

2. _____ _____

3. _____ ____

4. _____ ____

5. _____ ____

Pacheco ABA staff like to participate in holidays. Which holidays do you celebrate?

_____

Does your child participate in these childhood figures? (Circle those that apply)

Tooth fairy Santa Easter bunny Leprechaun

Medications: Please list any medications that your child is currently taking

Medication	**Dosage**	**Length of Time Taken**

Current Medical Conditions:

Please list any medical diagnosis:	Cerebral Palsy Autism/PDD___ Hyperactivity ADHD _____ ODD (noncompliance)_____
Please list any current allergies that your child may have:	
Please list any special nutritional needs:	
Are immunizations up to date?	

Skill Assessment

Language:

Does your child	**Yes or No**	**Comments**
Match objects or pictures		
Follows directions without visual cues		
Indicates wants and needs		(Using: words pictures or gestures)
Imitates sounds or words when modeled		
Uses words to ask for things		
Labels items he/she sees or hears		
Answers questions		
Speaks in sentences (If no, skip remaining questions)		Using: 3 5 8+ words
Participate in conversation?		

What are your main concerns regarding your child's language		

Play Skills:

Does your child	Yes or No	Comments
look at books		
Complete task completion toys (i.e. puzzle)		
Play with toys using them like real items		
Play games by the rules		
Play appropriately on his or her own for up to 5minutes		

What are things the person like and reinforcing to him/her?

1. Food Items:

_____

2. Toys and Objects:

_____

3. Activities at home:

_____

4. Activities in the community:

_____

5. Other:

_____

Parent/Guardian _____ Date

Clinician _____Date