



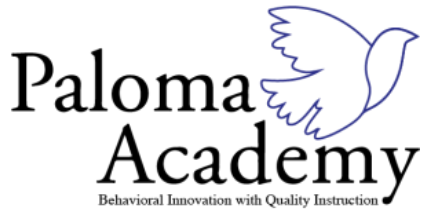
## Therapy Intake

### Parent/ Guardian Information

<b>Parent/ Guardian 1 Name:</b> <b>(First, MI, Last)</b>	
<b>Parent/ Guardian 1 Email:</b>	
<b>Parent/ Guardian 1 Phone #:</b>	
<b>Parent/ Guardian 2 Name:</b> <b>(First, MI, Last)</b>	
<b>Parent/ Guardian 2 Email:</b>	
<b>Parent/ Guardian 2 Phone #:</b>	
<b>Primary Street Address:</b> <b>(Street number, City, State, Zip)</b>	
<b>Martial Status:</b>	

### Child's Information

<b>Child's Name:</b> <b>(First, MI, Last)</b>	
<b>Childs' Date of Birth:</b>	
<b>Child's SSN:</b>	
<b>Primary Street Address</b>	



### Insurance Information

Name of Insurance Company: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Social Security # of Policyholder: \_\_\_\_\_

DOB of Policy holder: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

### Family Information

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parents are: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_

If divorced, who has physical custody? \_\_\_\_\_ Is it full or joint? \_\_\_\_\_

Is this child: Your biological child \_\_\_\_\_ Stepchild \_\_\_\_\_ Adopted child \_\_\_\_\_ Foster child \_\_\_\_\_

Persons living in the home: \_\_\_\_\_

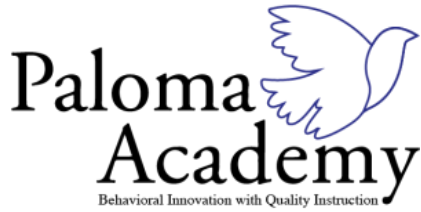
Other children you have concerns for: \_\_\_\_\_

### Family Mental Health History: (check all that apply/ list relation to client)

\_\_\_ Autism \_\_\_\_\_ \_\_\_ Bipolar \_\_\_\_\_

\_\_\_ Depression \_\_\_\_\_ \_\_\_ ADHD \_\_\_\_\_

\_\_\_ Anxiety \_\_\_\_\_ \_\_\_ Other \_\_\_\_\_



## Medical Information

Name of current physician: \_\_\_\_\_

Physician address: \_\_\_\_\_

Physician phone: \_\_\_\_\_

Name of diagnosing physician: \_\_\_\_\_ Date diagnosed: \_\_\_\_\_

Does your child have any current health conditions? If so, please explain below

\_\_\_\_\_

\_\_\_\_\_

Please list any medication that your child is currently taking.

Medication	Dosage	Frequency	Purpose	Side effects

**Does your child currently have any diagnosis? If so, please state below. \* Required for insurance coverage.**

Diagnosis	Diagnosing Physician	Date diagnosed	Diagnosis code



## Educational Information

Does your child attend school? If so, please complete the information below.

Name of school: \_\_\_\_\_

Classroom type: \_\_\_\_\_

Teacher/ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

School Phone number: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Please list special education services your child receives (IEP/ 504/ behavior plan):

\_\_\_\_\_  
\_\_\_\_\_

Current/ Previous Therapy Provider Information (*please attach most recent evaluations*):

**Behavioral Provider Name:** \_\_\_\_\_

Contact Name/ Phone: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Please state the therapy outcomes:

\_\_\_\_\_  
\_\_\_\_\_

**Speech Therapy Provider Name:** \_\_\_\_\_

Contact Name/ Phone: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Please state the therapy outcomes:

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**Occupational Therapy Provider Name:** \_\_\_\_\_

Contact Name/ Phone: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Please state the therapy outcomes:

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**Other Therapy Provider Name:** \_\_\_\_\_

Contact Name/ Phone: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Please state the therapy outcomes:

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**Child's Current Behaviors and Expected Outcomes:**

**Communication Skills: Primary method of communication**

Picture Communication  Sign Language  ACC  Verbal  Gestures

Comments: \_\_\_\_\_

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**Barriers to Communication:**  Impaired Articulation  Impaired Mand (requests)

Impaired Tact (label)  Echoic (repeats)  Scrolling  Impaired Echoic (difficulty repeating)  Impaired Intraverbal (sentence fill- ins/ conversation skills)  Prompt Dependent  Weak Speaker Skills  Weak Listener Skills  Weak Interpretation of Non-Verbal Communication

Comments: \_\_\_\_\_

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**Social and play:**

Does your child seek out interaction with  Parents  Siblings  Other adults  Peers

Does your child play  Independently  Next to other children  Only by him/herself

What play skills does your child have?  Plays with toys appropriately  Plays easy card games appropriately  Play board games  Takes turns  Following the rules of the game  Keeps score

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Behavior:**  Physical stereotypical behavior  Verbal stereotypical behavior

Perseverations

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Challenging Behavior:**

1. Physical aggression

**Function of the physical aggression:**  to get attention  to escape, avoid non-preferred tasks, demands  to get a preferred item, activities  for no obvious reason or self-stimulating

2. Self-injurious behavior (SIB)

**Function of the SIB:**  to get attention  to escape, avoid non-preferred tasks, demands  to get a preferred item, activities  for no obvious reason or self-stimulating

3. Running from area

**Function of running:**  to get attention  to escape, avoid non-preferred tasks, demands  to get a preferred item, activities  for no obvious reason or self-stimulating

4. Verbal aggression

**Function of verbal aggression:**  to get attention  to escape, avoid non-preferred tasks, demands  to get a preferred item, activities  for no obvious reason or self-stimulating

5. Yelling, screaming

**Function of yelling/screaming:**  to get attention  to escape, avoid non-preferred tasks, demands  to get a preferred item, activities  for no obvious reason or self-stimulating

6. Other  \_\_\_\_\_

**Function of other behavior(s):**  to get attention  to escape, avoid non-preferred tasks, demands  to get a preferred item, activities  for no obvious reason or self-stimulating

**Triggers** (if known) \_\_\_\_\_

Settings:

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Frequency:

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Intensity:

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**Function of the behavior:**  to get attention  to escape, avoid non-preferred tasks, demands  to get a preferred item, activities  for no obvious reason or self-stimulating

**Variables that may contribute to aversive behaviors & impede learning:**  Auditory Noise

Visual Distractions  Environment  Time  Crowds  Proximity to others

Transitions  Limited MO's (motivation)  Failure to Generalize skills (to other people, places, or behavior)  Negative Behaviors  Lack of Instructional Control  Impaired Motor Imitation  Sensory Defensive  Impaired Visual Perceptual Skills  Impaired Social Skills

Prompt Dependent  Impaired Scanning  Impaired Attending  Reinforcement Dependent  Self Stimulation  Obsessive- Compulsive Behaviors  Hyperactive Behavior

**Adaptive Living Concerns:**  Toileting  Eating  Dressing  Independent Play  Social Play  Group Skills  Fine Motor  Gross Motor  Household Routine  Bathing

Tooth brushing  Hair  Cleaning  Cooking  Leisure Time

**Reinforcers:** (please list anything that your child enjoys or is motivated by)

**Food:** \_\_\_\_\_

Toys: \_\_\_\_\_

Activities: \_\_\_\_\_

Social: \_\_\_\_\_

### PARENT/ FAMILY PRIORITIES & PREFERENCES

Top three areas/goals you would like to see change for your child in the next 6 months:

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Preferences:** *preferences include any items that your child enjoys or finds reinforcing and that may be used in treatment.*

a. Edibles: \_\_\_\_\_

b. Toys: \_\_\_\_\_

c. Activities: \_\_\_\_\_

d. Other: \_\_\_\_\_

**Aversives:** *aversives include anything that triggers problem behaviors or that your child tends to avoid.*

a. Sounds: \_\_\_\_\_

b. People/ places: \_\_\_\_\_

c. Demands: \_\_\_\_\_

d. Other: \_\_\_\_\_



Please provide detail regarding any other concerns of your child's development, if any.

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Please describe any other problem behaviors or interfering behaviors of concern.

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Please state the expectations/ goals that you have for your child while engaging in a behavioral program.

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Please list any other information that may be helpful while assessing and/ or conducting therapy with your child.

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## **Applied Behavior Analysis (ABA)**

### **Program Information**

#### ***Description***

Our ABA/ Verbal Behavior program is designed for children who have Autism Spectrum Disorder or other developmental disorders. The program includes 1:1 therapy from a Registered Behavior Technician, Board Certified Assistant Behavior Analyst, or Board Certified Behavior Analyst for a range of 10-40 hours per week to teach skills such as language, communication, self- help skills, social skills, academic and replacement skills for problem behavior.

#### ***Intake Procedure***

An initial assessment is conducted with parent(s) or caregivers and child, which takes approximately 2 hours depending on the skill level of the child. Based on the information received from the assessment, the following programs are mandatory for the client to receive ABA therapy:

- 10-40 hours per week of individualized instruction by a trained verbal behavior therapist, BCaBA, or BCBA
- Weekly program review and maintenance by BCBA or BCaBA
- Biweekly or monthly supervision of program by BCBA or BCaBA
- Monthly parent trainings- mandatory or client is subject to discharge from ABA therapy
- Biweekly or monthly program updates by BCBA or BCaBA

### **Behavior Reduction Program Information**

#### ***Description***

Our behavior reduction program is designed for children who may or may not have a diagnosis but who engage in disruptive behavior in the home, school or community settings. This

program focuses on teaching parents, teachers and other caregiver how to effectively decrease a child's disruptive behavior and increase compliance and other appropriate behaviors.

### ***Intake Procedure***

A Functional Assessment is conducted with the caregiver/ school staff in order to collect information regarding the behaviors of concern.

- Initial Behavior Interview and Behavior Assessments are conducted with family and/ or school staff at our office
- Records review
- Observation(s) of problem behavior in natural environment
- Review data collected by caregiver and/ or school staff
- Develop formal written recommendations
- Review recommendations with caregiver and/or school staff at our office
- Follow- up visit(s) to model recommended interventions



## **Client Services Agreement**

This Agreement, effective on the date that the last party signs the Agreement ( the “ Effective Date”), is by and between Paloma Academy and ( the “Client”)(Paloma Academy and Client are referred to collectively as the “ Parties”). The Parties agree as follows:

### **1. Term of Agreement**

This Agreement remains in effect from the Effective Date until either party terminates this Agreement by giving 10 days written notice.

### **2. Services Provided by Paloma Academy**

Client agrees to cooperate with Paloma Academy’s efforts to provide services to Client’s child and Client’s family and Client agrees to participate in the treatment process and will follow through with any interventions recommended by Paloma Academy. Paloma Academy will supervise and monitor services provided to Client and/or Client’s child by individual therapists and consultants who are employed by Paloma Academy.

### **3. Payment for Services**

#### **A. Private Pay**

Clients without a current insurance authorization, who are paying privately for services, agree to pay for all services. Services will be billed bi-weekly.

#### **B. Insurance Policies**

If current insurance authorization is on file, Client authorizes Paloma Academy to file insurance claims on Client’s behalf. Client also agrees to pay all co-payments, deductibles and fees for coinsurance, billed monthly. Even though Paloma Academy will verify eligibility and benefits, Clients should be advised that a Statement of Benefits provided by an insurance carrier is never a guarantee of payment. Client also acknowledges that Paloma Academy may temporarily suspend services until payment had been received.

#### **C. Billed Services**

In addition to assessments and direct therapy services, the following additional services may be billed in order to ensure optimal outcomes for your child’s progress:

- a. Monthly Program Updates
- b. Therapist Supervision
- c. Review of Data and Graphs
- d. Development of Program Materials
- e. Parent Meetings and Training
- f. School Meetings and Consultation
- g. Behavior Plan Development
- h. Reports Required by Insurance Carriers
- i. Travel Fees, when applicable
- j. Telephone Consultations

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Parent Signature

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Date