Therapy Intake

Parent/ Guardian Information

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

Child's Information

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

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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 _____

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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

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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:

_____

_____

Occupational Therapy Provider Name: _____

Contact Name/ Phone: _____

Dates of Service: _____

Please state the therapy outcomes:

_____

_____

Other Therapy Provider Name: _____

Contact Name/ Phone: _____

Dates of Service: _____

Please state the therapy outcomes:

_____

_____

Child's Current Behaviors and Expected Outcomes:

Communication Skills: Primary method of communication

☐ Picture Communication ☐ Sign Language ☐ ACC ☐ Verbal ☐ Gestures

Comments: _____

_____

_____

_____

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: _____

_____

_____

_____

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:

_____

Frequency:

_____

Intensity:

_____

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 uses 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.

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____ _____

Parent Signature Date