ADVENTURES *with* AUTISM

INTAKE PACKET

Thank you for selecting us at Adventures with Autism to help you meet the needs of your child!

The attached packet of information will help inform you about Adventures with Autism policies and procedures, and allow you time to gather information prior to your intake appointment.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be to assist you and your family. If at any time in this process you have any questions please contact us. We look forward to meeting you and your child!

PERSONAL INFORMATION

Participant's Name and Nickname:		
DOB:	Grade:	Age:
Gender:		
Address:	City:	State:
Zip:		
ICD-10 Diagnosis:		

PARENT/LEGAL GUARDIAN INFORMATION

Parent #1 Name:		
Address**:**	City:	State:
E-mail:	Home #:	Cell #
Zip:		
Occupation:		
Employer:		
Marital Status:		
Parent #2 Name:		
Address:	City:	State:
E-mail:	Home #:	Cell #
Zip:		
Occupation:		
Employer:		
Please indicate the primary contact person:		

Does either parent's job require him/her to be away from home long hours or extended periods?

_____

_____

SIBLINGS

Name	**Age**	**Relationship**	**Lives in home?**
_____	_____	_____	**Y/N**
_____	_____	_____	**Y/N**
_____	_____	_____	**Y/N**
_____	_____	_____	**Y/N**

WHAT TYPES OF GROUPS WOULD YOUR CHILD LIKE TO PARTICIPATE IN?

SOCIAL SKILLS:
Days/Times:

ACTIVITY GROUPS
Days/Times:

APPLIED BEHAVIOR ANALYSIS SERVICES: (Please note: ABA is a high intensity service that takes place 5 days per week in our clinic)
Days/Times available for services:

IEP/SCHOOL CONSULTATION:
Date requesting:
Service requested:

PRIVATE BEHAVIOR EVALUATION:

Date requesting:
Service requested:

Does your child currently receive (or have an authorization for) ABA services? ___

If so, who provides the service or completed the initial assessment and when?

_____

_____

INSURANCE INFORMATION

Name of Insurance Company:
Name of Policyholder:
Insurance Address:
Phone Number:
Member ID:
Group ID:

MEDICAL INFORMATION

Name of physician: _____

Physician address: _____

Physician phone: (___)_____

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

_____

_____

Please list any medications that your child is currently taking.

Medication	Dosage	Frequency	Side Effects

Does your child have any diagnoses*? If so, please state below – required for insurance coverage.

Diagnosis	Diagnosing Physician	Date Diagnosed	Diagnosis Code

DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

Rolled over consistently	_____	Said 1st word intelligible to stranger	_____
Sat up unsupported	_____	Used sentences regularly	_____
Stood	_____	Toilet Trained during the day	_____
Crawled	_____	Walked Unassisted	_____

2. Please indicate if your child is experiencing any of the following: (Please use Y/N)

   Problems with eating? _____

   Isolated social from peers? _____

   Problems sleeping? _____

   Anxiety? _____

   Hoarding? _____

   Aggressive behaviors? _____

3. Child's current height: _____ Ft. _____ Inches Weight: _____ Lbs.
4. Does your child have any vision problems? _____
5. Does your child have any hearing problems? _____
   a. Date of last hearing test and who performed? _____

Discipline Information

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed"

Intervention	Very Unlikely 1	2	3	4	Very Likely 5	Effectiveness (see below)	Least effective:
Let situation go							
Take away a privilege							
Assign an additional chore							
Take away something material							
Send to room							
Physical punishment							
Yell at child							
Send to time out							

Please list any other strategies you may use: _____

_____

_____

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please identify the LEAST effective strategy with an "X".

What percentage of discipline is handled by each of the following:

Father:_____% Mother:_____%

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: (___)_____

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:

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

_____
_____
_____
_____

Please describe any 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:

_____
_____
_____

*Please attach any assessments or evaluations that may aid in developing your child's program or behavioral interventions

Informed Consent for Behavioral Services

I hereby voluntarily apply for and consent to services by Adventures with Autism. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand and agree that my disclosures and communications are considered privileged and confidential expect to the extent that I authorize a release of information, or under certain other conditions listed below: (1) where abuse or harmful neglect of children, the elderly, or disabled or incompetent individual is known or reasonable suspected; (2) where such information is necessary for the company to pursue payment for services rendered; (3) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist; (4) where the client is examined pursuant to court order. I hold Adventures with Autism harmless for releasing information under the above conditions.

Signature	Date
Printed Name	Name of Client