Thrive Together Therapy, Inc.

10063 Rockwell School Dr, Unit D

Spanish Fort, AL 36527

Dear Prospective Client & Family,

Thank you for your interest in our services. We are excited to get to know you and your family! Please complete the following Intake Application to provide us with information so we may begin to assess your family's needs.

There are additional documents that will need to be submitted to your family's file. These are required for both securing a spot on our waitlist and beginning the path towards treatment.

Once you have completed the documents, you may submit them via:

Info@thrive2gethertherapy.com

Thank you again and we look forward to working together.

Sincerely,

Scott Hadley,

President/CEO,

Thrive Together Therapy, Inc.

INSTRUCTIONS

Please complete and submit this screening form to schedule an appointment for an evaluation.
You may submit this completed form to: **Info@thrive2gethertherapy.com**

The documents need to be submitted prior to the start of services.

NUMBERS 1-7 WILL NEED TO BE SUBMITTED TO RESERVE A SPOT ON OUR WAIT LIST.

EVERYONE BEGINS ON THE WAITLIST TO BE CALLED FOR SERVICES.

1. Competed Intake Application Form
2. Formal Autism Diagnostic Information, i.e. – ADOS-2, BOSA, CARS, etc.
3. Referral for ABA Therapy from your Primary Care Physician
   ***Must include Diagnosis and Severity Level ***
4. Last Well Visit with Pediatrician
5. Adaptive Assessment, i.e. – Vineland, ABAS, etc.
6. Cognitive Assessment, i.e. – WISC, WAIS
7. Copy of Insurance Card(s) Front and Back

Numbers 8-14 can be addressed during the initial intake meeting once an opening becomes available.

8. Copy of Driver's License or Government Issued ID
9. Consent for Assessment and Treatment
10. All release forms completed and submitted
11. Acknowledgement of Receipt of Parent Handbook
12. Your child's most recent IEP/BIP if applicable
13. Records of therapy (previous and current) for your child
14. Any documents related to services being received such as past intervention reports, or other relevant documents

INTAKE APPLICATION

Client Information

Patient's Name: Date of Birth: / /

Age: Gender:

Home Address: Unit:

City: State: Zip:

Primary Diagnosis: Age of Diagnosis:

Name of Diagnosing Physician:

Do you have a report from the physician? Yes No

Secondary Diagnosis?

Spiritual Beliefs:

Cultural Beliefs:

Any other personal beliefs that may influence care?

Family Information

Mother/ Guardian #1 Name:

Primary Guardian? ☐ Yes No Main Phone:

Home Address: Unit:

City: State: Zip:

Employer: Work Phone:

Primary Email:

Preferred Contact Method: ☐ Email Text Phone

Father/ Guardian #2 Name:

Primary Guardian? ☐ Yes No Main Phone:

Home Address: Unit:

City: State: Zip:

Employer: Work Phone:

Primary Email:

Preferred Contact Method: ☐ Email Text Phone

Any relevant legal issues? ☐ Yes No If yes, please explain:

Intake Application

Emergency Contact Information

Emergency Contact #1

Name: Phone:

Relationship:

Emergency Contact #2

Name: Phone:

Relationship:

Emergency Contact #3

Name: Phone:

Relationship:

Siblings

Does the Client have any siblings? ☐ Yes No

If yes, continue below. If No, please skip to Financially Responsible Person

Name: Age:

Does the sibling have a diagnosis? ☐ Yes ☐ No If yes, please describe:

Name: Age:

Does the sibling have a diagnosis? ☐ Yes No If yes, please describe:

Name: Age:

Does the sibling have a diagnosis? ☐ Yes No If yes, please describe:

Name: Age:

Does the sibling have a diagnosis? ☐ Yes No If yes, please describe:

INTAKE APPLICATION

Financially Responsible Person

Name: | Main Phone:
Date of Birth: | Social Security Number:
Home Address: | Unit:
City: | State: | Zip:
Employer: | Work Phone:
Employer Address:

Primary Insurance Information
(Please bring a copy of your card to your initial appointment.)

Plan Name: | Phone Number:
ID Number: | Fax Number:
Group Policy Number: | Effective Date:
Policy Holder Name: | Policy Holder Phone:
Policy Holder Date of Birth: | Primary Insurance Copay (if known): $
Primary Insurance Deductible (if known): $
Primary Insurance Policy Holder Employer:

Secondary Insurance Information
(Please bring a copy of your card to your initial appointment.)

Plan Name: | Phone Number:
ID Number: | Fax Number:
Group Policy Number: | Effective Date:
Policy Holder Name: | Policy Holder Phone:
Policy Holder Date of Birth: | Secondary Insurance Copay (if known):$
Secondary Insurance Deductible (if known): $
Secondary Insurance Policy Holder Employer:

Intake Application

Medical Information

Primary Care Physician: ______________________________

Address: ______________________________

Phone: ______________________________ Fax: ______________

Other Physician Name: ______________________________

Address: ______________________________

Phone: ______________________________ Fax: ______________

Other Physician Name: ______________________________

Address: ______________________________

Phone: ______________________________ Fax: ______________

Has your child been immunized? ☐ Yes No If yes, check all that apply:

- ☐ Hib (Haemophilus Influenzae)
- ☐ PCV13 (Pneumococcal conjugate)
- ☐ IPV (Inactivated Poliovirus)
- ☐ HPV (>11 yrs Human Papillomavirus)
- ☐ DTaP (<7 yrs Diphtheria, Tetanus, Whooping Cough)
- ☐ Tdap (>7 yrs Diphtheria, Tetanus, Whooping Cough)
- ☐ Meningococcal (>11 yrs)
- ☐ IVV; LAIV (Influenza)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Rotavirus
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ VAR (Varicella)
- ☐ Other______________________________

____

Please list all current medications the client is taking:

Medication Name	Dosage	Frequency	Reason

INTAKE APPLICATION

Please list and describe any other medical diets, allergies, conditions, diagnoses, etc. that we need to consider when delivering therapy:

Has the patient had a hearing or speech evaluation? ☐ Yes No If yes, please list location where they were last seen:

Evaluation #1:

Address:

Phone: Fax:

Evaluation #2:

Address:

Phone: Fax:

Has the client been diagnosed with or experienced any of the following?

☐ ADD/ ADHD

☐ Anxiety

☐ Asperger Disorder

☐ Autism

☐ Bipolar Disorder

☐ Cerebral Palsy

☐ Compulsive Behavior

☐ Depression

☐ Down Syndrome

☐ Epilepsy

☐ Hearing Problems

☐ Heart Disease

☐ Intellectual Disabilities

☐ Language Delays

☐ Learning Disabilities

☐ Migraines

☐ Obsessive Behavior

☐ Schizophrenia

☐ Seizures

☐ Social Difficulties

☐ Tics

☐ Verbal Apraxia

☐ Vision Problems

☐ Other:___________________________

INTAKE APPLICATION

Does the patient currently receive, or have they previously received any of the following therapies: (Please check all that apply.)

☐ ABA Therapy

☐ Behavioral Health

☐ Speech Therapy

☐ Occupational Therapy

☐ Physical Therapy

☐ Hearing Services Vision Services

☐ Feeding Therapy

☐ Music/Dance Therapy

☐ Other:________________________

Behavioral Concerns

Please check all that apply:

☐ Aggression

☐ Attention Problems

☐ Bolting/ Leaving Area

☐ Crying/ Whining

☐ Eating/ Feeding Problems

☐ History of Abuse

☐ Mental Health Problems

☐ Noncompliance

☐ Property Destruction

☐ Screaming

☐ Self-Injury

☐ Self-Stimulating Behavior

☐ Sleep Problems

☐ Tantrums

☐ Toileting Problems

☐ Other:_______________________________

Therapy Goals

Describe Your Child: ____

____

____

____

What are your therapy goals? ____

____

____

____

INTAKE APPLICATION

What are your primary concerns?

Is there anything else you would like to share?

Completed By:

Name

Date

Notice of Nondiscriminatory Policy as to Clients

It is the policy of Thrive Together Therapy, inc. to make therapeutic decisions without regard to race, color, religion, sex, sexual orientation, gender identity, gender expression, marital status, national or ethnic origin, age, veteran status, or the presence of a disability.