GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

# ABA Services Intake Form

## Person Completing this Form

Name: _____ ☐Parent ☐Guardian ☐Other: _____

Phone: _____ Email: _____

Are you authorized to consent for this individual's healthcare? ☐Yes ☐No

## Client Information

First Name: _____ Last Name: _____

Gender: ☐ Female ☐ Male ☐ Non-binary Birthdate: _____ SSN: _____

Address: _____

Please answer the following questions about the child's living situation:

A. Are the child's parents Divorced/Separated? ☐Yes ☐No
   a. If Divorced/Separated: ☐Joint ☐Sole
      Who is responsible for making medical decisions for the child?
   b. If sole custody, please specify which parent: _____
   c. With whom does the child reside? _____

B. Household #1: _____ % of time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

C. Household #2: _____ % of time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

D. Are both parents aware of services being sought at the Grand Valley Behavior? ☐Yes ☐No
   a. Does your child have a Guardian Ad Litem? ☐Yes ☐No
      If Yes, please provide their name: _____

E. Names and ages of any other siblings:
   _____
   _____

F. Primary Language: ☐English ☐Other: Specify _____
   Percent time child is exposed to non-English language(s): % of time _____

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

## Previous Evaluations/Assessments

Please list any school testing and/ or other evaluations of the client's skills.

Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor? ☐Yes ☐No ☐Unknown

If yes, please provide the following information:

A. Name: _____ Type of Specialist: _____ Date of evaluation: _____
Purpose of Evaluation / Services: _____
Results of Evaluation: _____
_____

B. Name: _____ Type of Specialist: _____ Date of evaluation: _____
Purpose of Evaluation / Services: _____
Results of Evaluation: _____
_____

C. Name: _____ Type of Specialist: _____ Date of evaluation: _____
Purpose of Evaluation / Services: _____
Results of Evaluation: _____
_____

## Educational History

Please list the schools attended from most recent.

Is the client currently enrolled in school or Birth-3 Services? ☐Yes ☐ No
School Name: _____ School District: _____
Program or Grade level: _____

Please list any other schools that the client has attended:

A. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____
B. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____
C. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____

Is the client receiving or has the client received special services or accommodations at school? ☐Yes ☐No

If yes, please explain what type: (e.g. IEP, IFSP, 504 Plan)

_____

_____

_____

_____

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

## Client's Interests

Please indicate anything that the clinicians should know when working with him/her.

A. Preferences (favorite activities, food, interests/topics, sensory):

B. Dislikes (aversions):

C. Other:

## Concerns

A. Reason for seeking ABA Services [Please explain]:

B. Please list client strengths:

Developmental Concerns [Please indicate by marking the box and explaining each domain]

☐Cognitive/Learning

☐Motor

Po box 2924
Grand Junction, CO 81502

970-317-7175

info@grandvalleybehavior.com

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

☐Behavior

☐Language

☐Social

☐Peer Interaction

☐Play / Leisure

☐Self-Help (Dressing/Toileting/Feeding/Etc.)

☐Dietary / Allergies

☐Other

Po box 2924
Grand Junction, CO 81502

970-317-7175

info@grandvalleybehavior.com

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

☐Academics (Reading/Writing/Math)

☐Executive Functioning (Organization/Flexibility/Attention)

## Description of Services

Applied Behavior Analysis (ABA) Intervention Services: Board Certified Behavior Analysts (BCBAs) provide evidence-based treatment using Applied Behavior Analysis (ABA) strategies to teach new skills, increase emerging skills, address challenging behavior, and support individuals with autism in a variety of settings.

- ☐ Early Intensive Behavioral Intervention (EIBI): The BCBA works with families to develop, implement, and refine intensive and comprehensive ABA-based programs individualized based on each child's strengths and needs. Services are provided in-home, in clinic, in community settings, and via telehealth (when necessary) and are implemented by behavior technicians and supervised by the BCBA. Services typically range between 20 and 40 hours per week and lasts 2 to 3 years. EIBI
- ☐ Behavioral Intervention Program: The BCBA works with families to develop, implement, and refine an ABA-based program, individualized for each chi. Home-based programs are implemented by behavior technicians and supervised by the BCBA.

## Hours of Availability

Please mark the times you and the client ARE available for services.

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| 8:00 | | | | | |
| 9:00 | | | | | |
| 10:00 | | | | | |
| 11:00 | | | | | |
| 12:00 | | | | | |
| 1:00 | | | | | |
| 2:00 | | | | | |
| 3:00 | | | | | |
| 4:00 | | | | | |
| 5:00 | | | | | |
| 6:00 | | | | | |

## Additional Comments

Po box 2924
Grand Junction, CO 81502

970-317-7175

info@grandvalleybehavior.com

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

## Cultural Considerations

Please describe below important cultural practices, rituals, traditions, or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.

_____

_____

_____

_____

## Evaluations/Assessment Reports

Please attach a copy of your child's reports (please include all that apply):

- ☐Diagnostic Evaluation Report
- ☐IEP/IFSP/504 Plan
- ☐Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)
- ☐Prescription for ABA
- ☐Mental health directives
- ☐Medical advance directives
- ☐Powers of attorney
- ☐Discharge summaries or evaluations from any inpatient/outpatient services within the last 5 years
- ☐Least restrictive alternative orders
- ☐Other: _____

## Coordination of Care

Please list and provide contact info for all other providers for your child:

- ☐Primary care provider: _____ Contact: _____
- ☐School teacher: _____ Contact: _____
- ☐Speech Language Pathologist: _____ Contact: _____
- ☐Occupational Therapist: _____ Contact: _____
- ☐Other: _____ Contact: _____
- ☐Other: _____ Contact: _____
- ☐Other: _____ Contact: _____

Please list any medications your child is taking, the purpose of the medication, dosage and any concerns:

_____

_____

_____

_____

_____

_____

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

## Insurance information:

Please attach a copy of your insurance card (front and back)

Primary Insurance Company: ..... _____

Subscriber ID # (including letters): ..... _____

Group Number: _____

Secondary Insurance Company: ..... _____

Subscriber ID # (including letters) ..... _____

Group Number: _____

Insurance Policyholder Full Name: ..... _____

Insurance Policyholder Date of Birth: ..... _____

Insurance Policyholder Address: ..... _____

Insurance Policyholder Relationship: Self, Spouse, Child, Other: _____

## Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Patient Full Name: _____

Po box 2924
Grand Junction, CO 81502

970-317-7175

info@grandvalleybehavior.com