Balance & Behavior

3321 Georgia Avenue NW Ste. 3026
Washington, D.C. 20010

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Dear Parents/Caregivers,

Welcome to Balance & Behavior, L.L.C. We are excited to begin a productive and meaningful relationship with you and your loved ones. Please review and complete the following information.

- We require a prescription/order for the ABA services your child is to receive from his/her pediatrician or specialist (e.g., Developmental Pediatrician, Neurologist, or Psychiatrist) which should include diagnosis code. Please fax, mail, or bring a copy / have a copy with you for your initial appointment.

- We also require an authorization from the insurance provider prior to providing any services. Our office will assist you in the process of procuring the authorization for the services.

- Please provide a copy of your insurance card and ID card (e.g., driver's license).

- Your child's initial assessment and program design will generally take about 5 hours. A portion of this time will be spent observing your child, a portion will be spent interviewing you and other natural supports, and a portion will be spent in the development and writing of the treatment plan.

We look forward to meeting with you and your child. If you have any questions, please do not hesitate to call.

Sincerely,

Balance & Behavior, L.L.C.

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INTAKE SCREENING FORM

Instructions:
Please complete and submit this screening form to schedule an appointment for an evaluation. You may submit this completed form to:

E-mail: aba@balanceandbehavior.com

The following is a comprehensive list of what will need to be provided. Numbers 1-5 can be sent to BCBA via email before the initial meeting or given to BCBA in person. Numbers 6-7 can be addressed during the initial meeting.

1. Your child's most recent IEP/BIP
2. Records of therapy (previous and current) for your child.
3. Diagnostic Information
4. Insurance Cards (if applicable)
5. Any documents related to services being received such as past intervention reports, or other relevant documents.
6. Any special accommodation your child may use, such as a chewy, weighted blanket, communication devices.
7. BCBA/BCaBA will have additional questions regarding :

-Specific items your child is reinforced by_____

-Snacks_____

-Developmental history_____

-Sleep schedule_____

-Communication skills_____

-Adaptive skills (potty training)_____

-Problem Behaviors_____

Please answer to the best of your ability. If you do not know any answers, your Balance & Behavior BCBA will work with you closely to determine if it is relevant information necessary for treatment.

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BIOGRAPHICAL

Child's Name: _____ **DOB:** _____

Sponsor ID/Insurance Subscriber ID: _____

Caregiver/Legal Guardian #1

*Name:*_____

Address: _____

_____

Phone: (cell) _____

(home _____

(work) _____

Email: _____

Caregiver/Legal Guardian #2

Name: _____

Address: _____

_____

Phone: (cell) _____

(home _____

(work) _____

Email: _____

Who Lives in the Home? *(please include any pets so we can ensure proper employee placement for your home)*

_____

_____

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CURRENT MEDICAL/SCHOOL INFORMATION

- **Primary Care Physician:**

Name/Affiliation*:* _____

Address: _____

Phone Number: _____

- **School Information:**

Name of School & Teacher: _____

_____

Address : _____

_____

Phone Number: _____

Does your child have an active IEP? (YES / NO)

What grade level and placement setting does your child have at school?

(i.e. EC Classroom, General Education Setting, Resource)

_____

If permitted, can ABA services be provided in school for your child? _____

This is based on district permissions and your child's specific needs.

Are you looking to have school-based services in conjunction with home-based services for your child? (YES ___ / NO ___ / Not Applicable ___)

Other Service Providers (Speech/OT/etc.):

Please include Facility, Names of Providers, and Contact Information

_____

_____

_____

_____

_____

Medical/Behavioral History

Autism Diagnostic Info:

- **Diagnosing Date (month/year): _____**
- **Diagnosing Provider (name/credentials): _____**
- **Facility of Diagnosis (Name/State): _____**
- **Level of Diagnosis (i.e. 1, 2, or 3): _____**

Current Medications: _____

Allergies: _____

History of Seizures: _____

Any other Diagnoses (if none, please indicate):

_____

Family History of Autism or related disorders (i.e. OCD, ADHD, etc.) If none, please indicate:

_____ o

BEHAVIOR: Does your child have a history of **aggressive behavior** that can cause harm to self or others? If so, please provide a brief overview *(what it looks like, why it typically happens, and how often/how long the behavior can occur):*

_____

_____

_____

_____

If you answered "Yes," have there been any specific behavior interventions previously implemented for your child? (YES / NO / Not Applicable)

_____

_____

MAIN AREAS OF CONCERN

- **What is your child's main form of communication. Please indicate all that apply:**
  - **Verbally (with delays)** _____
  - **Verbally (age-appropriate)** _____
  - **Non-verbally (gestures only)** _____
  - **Communication Device** _____
  - **Picture Exchange (PECS)** _____
  - **Other** _____

- **In regard to receiving ABA services, what are your main areas of concern you would like to see an increase/decrease in with your child?**

  Ex: Communication, Behavior, Independence Skills, Social Skills, Potty Training, etc.

  _____

  _____

  _____

- **Does your child have any sensory-related needs and/or aversions related to sights, smells, or sounds? (YES ___ / NO ___) If you answered yes, please explain:**

  _____

  _____

- **Is there any other information important for Balance & Behavior to be aware of in relation to your child that could impact ABA services? (YES ___ / NO ___) If you answered yes, please explain:**

  _____

  _____

PRIOR PROFESSIONAL CONTACTS

PLEASE LIST ALL PAST AND CURRENT THERAPIES YOUR CHILD HAS RECEIVED BY COMPLETING THE BOXES BELOW

Service *(Please circle the services received)*	**Start/End Date (Month/Year)**	**How Often?** *(times per week/month)*	**Length of Sessions** *(In Minutes/hrs.)*	**Main Targeted Goals**	**Effect of Therapy** *(WORSE, NO CHANGE, IMPROVED)*	**Contact Information**
Occupational Therapy						
Physical Therapy						
Speech						
Early Intervention						

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CHILD AVAILABILITY FOR THERAPY SESSIONS

	MON	TUE	WED	THU	FRI	SAT	SUN
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							