Client Application

CLIENT INFORMATION

Child's Legal Name______________________________ Nickname______________________ Sex____

Date of Birth_____________Age:_______Years________Months_____ SS______________________

Primary Residence of Child________________________ City/State_______________Zip__________

Home Phone Number____

Insurance Carrier______________________________________Phone____________________________

Member Name____Member ID_______________________

PARENT/GUARDIAN INFORMATION

1st Guardian's Name___________________________________ Home Phone_____________________

Relationship__________________Email Address_____________________ Cell phone_____________

Address (if different from child)____

Employer________________________Title_____________________ Work Phone__________________

2nd Guardian's Name__________________________________ Home Phone____________________

Relationship__________________Email Address_____________________ Cell Phone____________

Address (if different from child)____

Employer________________________Title_____________________ Work Phone__________________

Are there circumstances about the custody of your child that we should know about, which limit sharing of, records, picking up of your child, etc? ____Yes _____No (It is the parent's/guardian's responsibility to keep Island Cove Behavioral Pediatrics, LLC informed of changes in custody by providing current and complete legal documents each year and after any changes).

ADDITIONAL AUTHORIZED CAREGIVERS AND EMERGENCY CONTACT

Please list the name, relationship, and phone number for ALL individuals who will be directly involved in your child's treatment and/or responsible during home sessions (e.g., babysitter/nanny, grandparents, other caregivers). Basic treatment information and/or session feedback may be provided to these individuals unless otherwise specified.

Name	Relationship	Phone Number	
			__Emergency contact only __ OK to provide feedback
			__Emergency contact only __ OK to provide feedback

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			__Emergency contact only __ OK to provide feedback
			__Emergency contact only __ OK to provide feedback

Preferred Hospital (in case of emergency)____

Address____ Phone_____________________________

REFERRING INFORMATION/PRESENTING CONCERNS

Who referred you to Island Cove Behavioral Pediatrics, LLC?_____________________________

Reason for Referral/Presenting Concerns:

____

____

____

____

MEDICAL HISTORY

Current Physician(s)/Health Care Provider(s):

Physician's Name_________________________ Name of Practice/Clinic____________________

Care Provided____________________________ Phone:___________________________________

Address____

Previous ABA Company/Clinic____

Length of Care Provided_____________________________ Phone_________________________

Address____

Medical History:

Has your child had any injuries/surgeries/major illness in past 6 to 12 months (If yes, provide description and date)

Does your child have a history of seizures? (If yes, specific name and dosage of any prescribed medication)

Does your child have an insect, drug, or Latex allergy? (If yes, please describe)

Please specify any dietary needs:

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__Vegetarian __ No Milk/Dairy __Soy __ Casein __ Whey __ Other (list)

Does your Child have any past or current diagnosis?

Diagnosis	Diagnosing Provider	When Diagnosed

**Please include a psychological evaluation and/or diagnostic reports.

Is your child currently prescribed any medications to address behavioral/psychiatric concerns?

Medication	Dosage	Prescribed for	Prescribing Physician

FAMILY/SOCIAL HISTORY

Please list all individuals within the home:

Name	Age	Relationship to child	Time spent with	Education Level	Known Diagnosis/ Behavioral Concerns

Did/Does anyone in your family have a diagnosis or challenge similar to your child?________
If so, what is the individual's relation to your child? What are the similarities in diagnosis or challenge?

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EDUCATIONAL HISTORY

School Name______________________Current Grade________ Current Teacher______________

Phone___________________ Contact Person (Name and Title) Address (Include County)____

Type of Class (seclusion, inclusion, blended, mainstream)___________________Ratio_________
Years Retained (if any)________________________________ Current Grades_________________
Current IEP:_____Yes_____No

Describe any of the following opportunities or accommodations your child has in school. Pull-out/Resource Room or Specialized Small Group Instruction:

Opportunities for Mainstreaming:

Other Relevant Accommodations:

Services Provided by School	How Frequently	Session Length	Individual/group?

Describe any concerns that you have or that have been reported to you specifically to the school setting.

Do these concerns require immediate attention?

CURRENT SKILL LEVELS

Communication

- Please circle the main form of communication your child uses: gestures, words, sign language, augmentative communication device, other. If other is selected, please describe:
- Does your child have approximately 100 or more words they are able to use? ___Yes__No
- Does your child talk about items that are not present?
- Please provide any other information you would like us to know about your child's communication:

Social Skills

- Does your child independently interact with their peers?___Yes____No
- Describe your child's current strengths socially:

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- Describe your child's current weakness socially:

- Please provide any other information you would like us to know about your child's social skills:

Self-Help Skills

- Is your child toilet trained? ___Yes___No

- Does your child have issues during meal times or food variety? ___Yes___No

- Is your child able to dress themselves independently? __Yes___No

- Please provide any other information you would like us to know about your child's self-help skills?

PROBLEM BEHAVIORS

Are there specific events that trigger problem behaviors? (Examples may be asking them to complete a task, telling your child that they cannot have a toy or activity, periods of low attention):

What do the behaviors typically look like? (Example may include: crying, hitting, kicking, throwing items, head banging):

How long do the behaviors typically last?

ACKNOWLEGEMENT

AS PARENT/GUARDIAN OF THE ABOVE, I VERIFY THAT THE INFORMATION PROVIDED IN THIS DOCUMENT IS CURRENT AND UNDERSTAND THAT I AM RESPONSIBLE FOR PROVIDING ANY UPDATES OR CHANGES TO THE INFORMATION TO ISLAND COVE BEHAVIORAL PEDIATRICS, LLC.

Signature of parent/guardian______________________________________Date_________________

Print Name____