NOVA
ABA Therapy & Mental Health Services

7617 Little River Turnpike; Ste110, Annandale, VA 22003
Tel: 571-355-6980; Fax: 703-663-8730
www.abatherapyofvirginia.com/

Client Prescreening

Childs Information			
Name:	**D.O.B.:**	**Age:**	**Sex:**
Home Address:		**State:**	**Zip:**
Primary Language:	**Secondary Language:**		
Primary Diagnosis:	**Who Gave Diagnosis:**		
Secondary Diagnosis:	**Who Gave Diagnosis:**		

Physician / Referrer Information	
Primary Physician:	**Primary Physician Phone:**
Referring Provider:	**Referring Provider Phone:**

Insurance and Guarantor Information		
Primary Insurance:	**Insurance Number:**	
Group Number:	**Sub. Name:**	**Sub. D.O.B.:**
Secondary Insurance:	**Insurance Number:**	
Group Number:	**Sub. Name:**	**Sub. D.O.B.:**

Authorized Caregiver Information		
Name:	**Relationship To Child:**	
Phone Number 1:	**Phone Number 2:**	
Home Address: (same as child) ☐	**Email:**	
Name:	**Relationship To Child:**	
Phone Number 1:	**Phone Number 2:**	
Home Address: (same as child)	**Email:**	

Does your child currently attend school? If yes, when?			
Does your child receive other therapies at this time?		Speech OT PT	Other:

Referral Questionnaire		
Have you had a provider approved to provide ABA services in the past?	Yes	No
If yes, have you received confirmation of discharge from pervious provider?	Yes	No
Has another company assessed or screened your child within the past 90 days?	Yes	No
Insurance requires that all providers write goals and document parental involvements. Do you agree to actively participate in this program with the understanding that if you do not actively participate, the service once authorized might not be renewed?	Yes	No
As part of your participation agreement, do you agree to purchase materials that will be used by the therapists specifically for your child with the understanding that any materials purchased by you will belong to No you and will remain in the house? Yes	Yes	No
Do agree to purchase reinforcement materials for your son or daughter and agree to withhold access to these materials during non-session times?	Yes	No

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Read the following statement to the caregiver before beginning the next portion of the prescreening assessment:
"I am now going to ask you some questions about your child's skills and deficits. Try to be as accurate as possible as it is important that you not over- or under-emphasize any current skills or deficits your child currently presents with."

Language Skills		
Can your child imitate any sounds, words, or phrases he or she hears?	☐ Yes	☐ No
Can your child effectively ask for things he or she may want or need?	☐ Yes	☐ No
Can your child vocally label things he or she sees in his or her environment?	☐ Yes	☐ No
Does your child possess conversational skills, i.e., talk with someone for several exchanges?	☐ Yes	☐ No
Does you child spontaneously communicate with others?	☐ Yes	☐ No

Social Skills		
Does your child comply with basic requests at a rate similar to other children his or her age?	☐ Yes	☐ No
Does your child make age appropriate eye contact with others when engaging them?	☐ Yes	☐ No
Does your child play with peers at an age appropriate level?	☐ Yes	☐ No
Does your child respond appropriately when someone says their name?	☐ Yes	☐ No
Does your child appear to struggle with understanding social norms or context specific behavior?	☐ Yes	No

Adaptive Skills		
Is your child completely toilet trained?	☐ Yes	☐ No
Can your child dress him or herself?	☐ Yes	☐ No
Can your child brush their teeth at an age appropriate level?	☐ Yes	☐ No
Can your child bathe at an age appropriate level?	☐ Yes	☐ No
Does your child have a basic understanding of safety skills in multiple environments?	☐ Yes	☐ No
Does your child sleep through the night without too many issues?	☐ Yes	☐ No

Sensory Hyper- or Hypo-sensitivities		
Does your child exhibit an unusual response to certain noises that do not seem to bother others?	☐ Yes	☐ No
Does your child appear distracted by background noises that others seem not to hear?	☐ Yes	☐ No
Does your child appear fearful of sudden touch, avoid hugs or touch from familiar adults?	☐ Yes	☐ No
Does your child appear fearful of crowds or avoid standing near others?	☐ Yes	☐ No
Does your child have age appropriate balance skills, i.e., doesn't fall often?	☐ Yes	☐ No
Does your child constantly touch people or textures, even when it is inappropriate or told to stop?	☐ Yes	☐ No
Does your child appear to not understand what is socially acceptable personal space?	☐ Yes	No
Does your child emit clumsy or uncoordinated movement more so than their peers?	☐ Yes	☐ No
Does your child have an extremely high tolerance to pain or indifference to pain?	☐ Yes	☐ No
Is your child constantly moving, fidgeting, spinning, finger flapping, etc.?	☐ Yes	☐ No

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Repetitive or Restricted Skills		
Does your child show an overwhelming interest in one or a limited number of things?	☐ Yes	☐ No
Does your child engage in specific routines or rituals and respond poorly if they are interrupted?	☐ Yes	No
Does your child repeat the same movements many times, e.g., body rocking, hand flapping?	☐ Yes	☐ No
Does your child line up or stack toys and/or play with toys in a manner they were not intended?	☐ Yes	☐ No
Is your child a picky eater, only eating a very limited number of foods?	☐ Yes	☐ No

Behavior Concerns				
In the past 3 months has your child:				
- Punched, slapped, pushed, or kicked others?	☐ Yes	☐ No	If yes,	
- Scratched others?	☐ Yes	☐ No	If yes,	
- Bite others?	☐ Yes	☐ No	If yes,	
- Spit at others?	☐ Yes	☐ No	If yes,	
- Punched or slapped self?	☐ Yes	☐ No	If yes,	
- Scratched self?	☐ Yes	☐ No	If yes,	
- Bite self?	☐ Yes	☐ No	If yes,	
- Banged head or other body part against items/surfaces?	☐ Yes	☐ No	If yes,	
- Verbally aggressed towards others (swearing, threatening)?	☐ Yes	☐ No	If yes,	
- Broke items or destroy property?	☐ Yes	☐ No	If yes,	
- Run away from adults in the home, school, or community?	☐ Yes	☐ No	If yes,	
- Engaged in severe tantrum behavior?	☐ Yes	☐ No	If yes,	

Monday	☐ No Availability;	☐ Anytime;	☐ Mornings (8am-12pm);	☐ Afternoons (12pm-4pm);	☐ Evenings (4pm-8pm)
Tuesday	☐ No Availability;	☐ Anytime;	☐ Mornings (8am-12pm);	☐ Afternoons (12pm-4pm);	☐ Evenings (4pm-8pm)
Wednesday	☐ No Availability;	☐ Anytime;	☐ Mornings (8am-12pm);	☐ Afternoons (12pm-4pm);	☐ Evenings (4pm-8pm)
Thursday	☐ No Availability;	☐ Anytime;	☐ Mornings (8am-12pm);	☐ Afternoons (12pm-4pm);	☐ Evenings (4pm-8pm)
Friday	☐ No Availability;	☐ Anytime;	☐ Mornings (8am-12pm);	☐ Afternoons (12pm-4pm);	☐ Evenings (4pm-8pm)
Saturday	☐ No Availability;	☐ Anytime;	☐ Mornings (8am-12pm);	☐ Afternoons (12pm-4pm);	☐ Evenings (4pm-8pm)
Sunday	☐ No Availability;	☐ Anytime;	☐ Mornings (8am-12pm);	☐ Afternoons (12pm-4pm);	☐ Evenings (4pm-8pm)

Prescreening Completed by:_____ Date: _____