



Clinic-Based Early Intensive Behavior Intervention

Potential Client Interest Form

Child Name:		Parent or Caregiver Name:	
Child Age:		Phone Number:	
City of Residence:		Email:	
Diagnosis:		Insurance Company:	
Current Services:		How did you hear about us?	

Self-Screening Questionnaire

My child is between the ages of 0-7 years of old	Yes	No
My child would benefit most from one-to-one instruction	Yes	No
My child has challenges making and keeping friends	Yes	No
My priority is to improve my child's developmental delays and/or impeding behaviors	Yes	No
I am able to participate in a parent education program	Yes	No
I have reliable transportation to take my child to clinic-based treatment appointments (including public systems)	Yes	No
I am able to commit to ensuring my child is present to receive 90% or more of their prescribed hours.	Yes	No
My child is available to attend his/her <i>*recommended</i> treatments based on the following schedule: <ul style="list-style-type: none"> • 0-5 y/o: 8am-12pm, 8am-4pm or 12pm-4pm M-F • 6-8 y/o: 3pm-6pm M-F <i>*the recommended number of hours is based on a prescription determined through a clinical assessment. Ex: just because a child is 4 years old does not mean they will attend clinic 8am-4pm</i>	Yes	No
I have reviewed Quality Behavior Solutions' website and policies	Yes	No