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In-Home ABA Program Intake Packet

Welcome!

Thank you for selecting us at Bright Minds Consulting, LLC. (BMC) to help you meet the needs of your child. We appreciate your having selected us to work with your child and family.

The attached packet of information will help inform you about Bright Minds Consulting, LLC. policies and procedures, and allow you time to gather information prior to your initial appointment.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be to assist you and your family. If at any time in this process, you have any questions, please contact us.

We look forward to meeting and working with you and your child,

Bright Minds Consulting, LLC.

Checklist:

- ☐ Intake Form
- ☐ Availability/Schedule Form
- ☐ Client Agreements and Consent Forms
- ☐ HIPPA Service Agreement and Consent Form
- ☐ Behavior Therapy Intervention Pricing Sheet

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INTAKE FORM

CHILD INFORMATION	Today's Date:
Last Name:	Age:
First Name:	Date of Birth:
Middle Name:	Gender:
Home phone:	Social Security Number:
Address:	City:
State: Zip code:	County:

Primary Diagnosis:	Date of Diagnosis:
Other Condition:	Date of Diagnosis:
Other Condition:	Date of Diagnosis:

PRESENT SCHOOL/PLACEMENT	
Name of School:	Years Attended:
Address:	Placement:
Phone:	Teachers Name:

PARENT/LEGAL GUARDIAN INFORMATION	
Full Name:	Full Name:
Address:	Address:
City: State: Zip code:	City: State: Zip code:
Email:	Email:
Cell Phone:	Cell Phone:
Home Phone:	Home Phone:
Relationship to Child:	Relationship to Child:

SOURCE OF FUNDING	☐ INSURANCE (Please fill out below)	☐ PRIVATE PAY
Insurance Provider:	Member ID:	
Group Number:	Provider Phone Number:	
Does your child have any OTHER health insurance than the one provided above? ☐ YES ☐ NO		
If yes, please list the requested information below:		
Insurance Provider:	Member ID:	
Group Number:	Provider Phone Number:	

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MEDICAL INFORMATION

Is your child on medication? ☐ YES ☐ NO

If yes, please list medication, administration times, and usage below:

Does your child have any allergies? ☐ YES ☐ NO

If yes, please list the allergies below:

Type of Medication	Dosage	Administration Time	Usage

Additional medications can be attached on a separate sheet of paper and stapled to this application.

Are there any medical conditions that need to be considered when delivering ABA treatment?

☐ Yes ☐ No If yes, please explain.

SUPPORTIVE SERVICES

What other services is your child currently receiving both in-school and out of school? Please enclose a copy of the child's most recent IEP or IFSP and therapy goals from each area that is checked.

Service/Therapy	Location	Hours/Week
☐ Early Intervention/ITDS	☐ School ☐ Home	
☐ Speech/Language Therapy	☐ School ☐ Home	
☐ Occupational Therapy	☐ School ☐ Home	
☐ Physical Therapy	☐ School ☐ Home	
☐ Hearing Services	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	

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Please describe any complication(s) during pregnancy or birth, if any.

What, if any, behavior issues does your child have? Ex., tantrum, self-injurious, aggressive towards others, etc., please explain.

What are your immediate goals for your child?

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What current communication skills does your child have? Ex., sign language, PECS, verbal. Please explain.

Additional Notes:

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

_____

Child's Name

_____ _____

Parent/Guardian Name Relationship to Child

_____ _____

Parent/Guardian Signature Date

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Availability for Services

Please fill in or mark the blocks of time in which you and your child are available for session(s).

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7 am							
8 am							
9 am							
10 am							
11 am							
12 pm							
1 pm							
2 pm							
3 pm							
4 pm							
5 pm							
6 pm							
7 pm							
8 pm							
9 pm							

Notes: