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New Client Intake Form

Client Information

Client Name: _____ Date of Birth: _____
Address:
_____
_____

Regarding the child's living situation:
Are the child's parents married/divorced/separated? (Please circle one)
Who is responsible for making medical decisions for the child? Joint_____ Sole____
If sole, please specify which parent: _____

Name of Parent/Guardian # 1: _____
Cell phone:_____ Work phone:_____
Email: _____

Name of Parent/Guardian #2: _____
Cell phone:_____ Work phone:_____
Email: _____

Names, ages, and relation to child of all other individuals in the home:
_____
_____
_____

Are both parents aware of ABA services being sought from Bright Steps? Yes / No
Are both parents on board with committing to and receiving services from Bright Steps? Yes / No

Primary Language (Please circle one): English Other (Specify: _____)

Previous Evaluations/Assessments
Diagnostic Evaluation:
Name of diagnosing specialist & office: _____
Type of specialist: _____ Date of evaluation: _____

Has the client ever been assessed/evaluated by an Occupational Therapist, Speech & Language Pathologist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor?

Name of specialist: _____
_____
Type of specialist: _____ Date of evaluation: _____
Purpose of evaluation/services: _____
Results of evaluation: _____

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Educational History:
Is the client currently enrolled in school or birth-3 services? Yes / No
School Name: _____
School District: _____ Program or Grade Level: _____

Please list any other schools the client has attended:
_____
_____

Is the client receiving or has the client received special services or accommodations at school? Yes / No
If yes, please explain what type (e..g. IEP, IFSP, 504 Plan):
_____
_____

ABA History:
Has your child ever received ABA therapy before? Yes / No
If yes, with which provider? _____
Reason/s for discharge? _____
Client Interests:
Preferences (favorite activities, foods, interests/topics, sensory):
_____
_____
Dislikes (aversions):
_____
_____
Other:
_____
_____

Concerns:
Reason/s for seeking ABA services:
_____
_____

Please list your child's strengths:
_____
_____
_____
_____

Developmental Concerns (Please indicate by marking the box and giving a brief description. Indicate the top 3 areas you would like to see improvement for your child in the next 6 months by circling the checked boxes.).

- ❏ Cognitive/Learning
  _____
- ❏ Motor
  _____
- ❏ Behavior
  _____
- ❏ Receptive Understanding of Language
  _____

- ❏ Expressive Communication of Language
  _____
- ❏ Social
  _____
- ❏ Play
  _____
- ❏ Self-Care
  _____
- ❏ Academics (Reading/Writing/Math)
  _____
- ❏ Executive Functioning (Organization/Flexibility/Attention)
  _____

Description of Available Services

Parent & Caregiver Training	Home-Based	Community-Based
Through our parent training service delivery, we aim to coach parents & family to hone their skills and confidence in helping their child grow and function in their daily life. We meet you where you need the support most, and provide you with the tools that you need for success.	Through our 1:1 home-based service delivery, your child is supported by a team of professionals to foster and guide their growth. Language-rich ABA sessions with a Behavior Technician are provided at least 3-4 times per week, as well as weekly consultation with a Board Certified Behavior Analyst to monitor progress.	Children on the Autism Spectrum can often display difficulties with numerous aspects of community engagement. These difficulties can lead to stressful interference in family life. Through our community-based support, we can provide both you and your child with the skills you need individually in order to be successful at the grocery store, doctor's office, dentist's office, the library, etc.

Hours of availability:
Services are provided Monday-Friday 8:00AM-5:30PM in BLOCK SCHEDULING

Session length recommendations specific to your child's needs will be provided upon completion of initial assessment with the Bright Steps assessment team. However, sessions are provided during the following blocks:

8AM-11:30AM 12-2:30PM 3-5:30PM

Below, please check off the box indicating you and your child ARE AVAILABLE during those times.

	Monday	Tuesday	Wednesday	Thursday	Friday
8A-11:30A					
12-2:30P					
3-6:30P					
Notes					

Cultural & Spiritual Considerations:
Please describe important cultural and/or spiritual practices, rituals, traditions, or beliefs that you feel are important for us to be aware of prior to initiating a therapeutic relationship: _____
_____
_____

Coordination of Care:
Please list and provide contact info for all other providers for your child:
Primary Care Provider: _____
Location/Office: _____ Contact #: _____

School teacher: _____
Location/Office: _____ Contact #: _____

Speech & Language Pathologist: _____
Location/Office: _____ Contact #: _____

Occupational Therapist: _____
Location/Office: _____ Contact #: _____

Physical Therapist: _____
Location/Office: _____ Contact #: _____

Feeding Therapist: _____
Location/Office: _____ Contact #: _____

Other: _____
Location/Office: _____ Contact #: _____

Other: _____
Location/Office: _____ Contact #: _____

Please list any allergies your child has as well as how the allergic reaction presents itself:

_____

_____

Does your child have an epipen? Yes / No

Please list any medications your child is taking, the purpose of the medication, dosage, and any concerns or additional information we should have regarding them:

_____

_____

_____

Copies, Evaluations, Assessment Reports:

- ❏ Please attach a copy of your child's insurance card (front & back)
- ❏ Please attach a copy of your child's current physical from their pediatrician
- ❏ Please attach a copy of your child's reports (please include all that apply)
    - ❏ Diagnostic Evaluation Report
    - ❏ If Diagnostic Report is over 1 years old, please also request and provide a current letter from your child's diagnosing doctor asserting the continued need for ABA services
    - ❏ IEP/IFSP/504 Plan
    - ❏ Specialist evaluations (SLP, OT, PT, etc.)
    - ❏ Discharge summaries from any prior ABA providers

Insurance / Billing Information & Authorization

- ❏ I am a private pay client and acknowledge it is my personal responsibility to pay for services.

OR

- ❏ I authorize my insurance provider/s listed below to make payments directly to Bright Steps Behavior Innovations LLC for services rendered.
- ❏ I understand that a copy of my insurance card (front & back) will be retained in my client/patient file for billing purposes.
- ❏ I agree that private information may be shared with my insurance carrier for billing purposes.
- ❏ I understand that if I do not want information shared that I may submit specific directions to Bright Steps Behavior Innovations (See Bright Steps Behavior Innovations Release Form).

Name of Primary Insurance Member: _____
Name of Insurance Carrier:
_____
Policy #: _____
Signature of Primary Insurance Member (REQUIRED for processing):

_____

_____

- Office Use Only -

- ❏ Date Intake Received: _____
- ❏ Insurance Benefit Confirmed:
  _____
- ❏ Date Phone Call to Primary Guardian: _____
- ❏ Date of Intake Meeting: _____
- ❏ Date of Assessment: _____

- ❏ Case Assigned to BCBA: _____
- ❏ Date Services Begin: _____