□Parent Training □ Consultation □ Direct Service □ Social Skills (PEERS) □ IEP Advocacy & Support
□ Sibling Services □ Individual Counseling □ Group Counseling □ Other: _____

Parent Name: _____
Home Address: _____
_____
Phone: _____
eMail: _____

Notes: _____
_____
_____
_____
_____
_____

Client Name: _____
Service Address: _____
_____
Gate code/etc: _____
Diagnosis: _____
Gender: _____
Date of Birth: _____
Primary Care MD:_____
-Phone: _____
-Fax: _____
(Click to upload copy of diagnosis and prescription for ABA therapy services)

Insurance Brand: _____
ID Number: _____
Provider Call Number: __ _____
Service Coordinator: _____
-Contact: _____

Co-Pay / Co insurance: _____
Deductable: _____
Out of Pocket Max: _____
Plan Year: _____
(click here to upload front of ID card)
(click here to upload back of ID card)

Special Factors:

□ Aggression: ○Verbal ○Physical
Self / Others Description: _____
_____
□ Language: ○Non Vocal: ○PECS ○Sign ○Echoic
Verbal: ○Minimal ○Functional ○Labored ○Fluent
□ Stereotypic Behaviors: ○Hand Flapping ○Odd Eye Gaze
○Other:_____
○Fixed Interests:_____
□ Energy Level: ○Low ○Average ○High ○Highly Variable
□ Physical Issues: _____
□ Sensory Issues: _____
□ Rare Diagnosis: _____
□ Compliance: ○All Adults ○Some Adults ○Certain Activities
Description: _____
□ Social Skills: ○Adults ○Same age Peers
○Inappropriate Group Selection ○ Enter/Exit Conversation
○Maintain a conversation appropriately ○Good Sportsmanship
Description: _____
□ Self-Care
○Toileting ○Bathing ○Hand Washing ○Dressing ○Teen/Adult
□ Play / Leisure Skills
○Limited attention to games ○Limited games of interest
○Odd toy use / limited toy skills
○Inappropriate times (up all night) ○iPad/iPod fixation

School District: _____
Attends: _____
IEP / 504: _____
-services: _____
_____
_____
_____
Advocate: _____
-Contact: _____
(click here to upload documents)

Other Details of Note:

_____
_____
_____
_____
_____
_____
_____
_____