Amazing Transformations

CLIENT INTAKE FORM

This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of time. Please feel free to add any additional information that may be helpful in understanding your child.

PLEASE PRINT

Name of Person Completing this form: _____

Legal Name of Child/Adolescent: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth: _____ Age: _____

Allergies / Medical Conditions: _____

Parent(s) / Guardian(s): _____

Home Address: _____
Street

_____ _____ _____
City State Zip

Home Telephone Number: ___-___-____ Work Phone(s) Mother: ____-____-_____
Father: ____-____-_____

Mobile Phone(s) Mother: ____-___-____
Father: ____-___-____

Email: _____

School Name:_____ District: _____ Grade: _____

School Telephone Number: _____

Current Teacher(s): _____

Who referred you? _____

Insurance Reimbursement Form

Child's Name:_____

Date of Birth_____ **Gender:**_____

Address:_____

City:_____**State:**_____**Zip:**_____

Home Phone Number:_____

Diagnosis: _____ **Date of Diagnosis:** _____

Diagnosed By: _____

Insured's Information:

Insurance Company:_____

Identification Number:_____

Group/PlanNumber:_____

Employer: _____

Insured's Name:_____ **Insured's date of Birth:**_____

Insured's Gender:_____ **Insured's Email:**_____

Please provide us with a copy of the front and back of your insurance identification card.

****A prescription blank or letter from your child's doctor (primary or specialist) with the diagnosis code AND note that ABA Therapy is required must be provided in order to obtain health insurance approval.***

****Most health insurance companies also request formal documentation of autism diagnosis from a medical provider's office.***

INDICATE PARRENT / GUARDIANS LIVING IN THE HOME:

Marital Status: Married –Divorced – Separated – Widowed – Single

- If divorced, who has physical custody? _____ Is it full or joint?_____
- Who has legal custody? _____ Is it full or joint? _____

Does either parent's job require him/her to be away from home long hours or extended periods?
_____

Siblings:

Name	Age	Relationship	Living in Home
_____	_____	_____	**Y/N**
_____	_____	_____	**Y/N**
_____	_____	_____	**Y/N**
_____	_____	_____	**Y/N**

Please list additional Sibling in the above format on the back of this page.

Has the child you are seeking services for been evaluated in the past? Yes / No
If Yes, please list the following information on the previous evaluation(s)

Who	Type	When	Copy Available
			Y/N
			Y/N
			Y/N
			Y/N

(If more evaluations need to be listed please use the space on the back of this page.)

Please provide us with any other information that you feel would be helpful to us in understanding your child on the back of this page.

ALLERGIES/MEDICAL HISTORY

List any operation, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

_____
_____

List any medications your child is currently taking or has taken for extended periods (give dosage level if possible):

_____
_____

With which hand does the child write:

_____

Does the child have any vision or hearing problems?

_____

Name of child's physician(s) _____

Practice Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

(Please list information on additional Physicians on the back of the page)

REASON FOR REFERRAL

Area(s) of Concern:

- **Behavior:** _____
- **Social Skills:** _____
- **Language:** _____
- **Self-Help / Functional:** _____

Please list the **five** things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sister, etc.

	Like Child to do More Often	Like Child to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____