



New Client Intake Form

First and Last name: _____ Date of Birth: _____ Age: _____ Sex: M ☐ F ☐

Insurance: _____ Ins. Id #: _____

Where are you interested in receiving ABA services: ☐ Home ☐ In School ☐ Center ☐ Unsure

What is your availability for services? (we provide services M - F 8 am - 5 pm)

Monday	Tuesday	Wednesday	Thursday	Friday

Guardian Information:

Parent/Guardian 1:

First and Last name: _____ Relation to client: _____

Phone: _____ Email address _____

Home Address: _____

Parent/Guardian 2:

First and Last name: _____ Relation to client: _____

Phone: _____ Email address _____

Home Address: _____

Medical information:

Date of Diagnosis: _____ Date of Referral: _____

Original Date of Date of diagnosis (if he/she has previously been diagnosed): _____

Diagnosed by whom: _____ Referred for ABA by whom: _____

Name of Primary Care Physician: _____

Does your child have any other (comorbid) diagnoses? No: ☐ Yes: ☐

If yes, please explain:

Does your child have any allergies or dietary restrictions: No ☐ Yes ☐ If yes, please explain :

Is your child taking any medications? No: ☐ Yes: ☐ (please list below)

History of services:

Has your child received ABA in the past: No: ☐ Yes: ☐

If yes, dates of services: _____

If yes, previous provider: _____

If yes, approximate hours of service weekly: _____

Does/did your child receive other ancillary services:

Speech: _____

OT: : _____

PT: : _____

Current schedule: _____ Past Schedule: _____

Educational placement: _____

School District: _____

Grade: _____

Does your child have an IEP?: Yes: ☐ No: ☐

If yes, please include your most recent IEP when submitting your documentation

Does the family present with any spiritual or cultural preferences that may impact ABA services (e.g. observe the sabbath, observe any other religious holidays, go to church during the week, etc.)

No: ☐ Yes: ☐ If yes, please explain : _____

Clinical information:

Why did you seek out ABA services: _____

Child's Strengths: What are your child's greatest strengths (e.g., skills, interests)?

Goals of Intervention: What goals would you like to achieve for your child and family?

Tell us about your family. Who lives in your house? Who is the child mostly around ect.

Social Skills:

How does your child do in social settings? How does he/she interact with others?

Does your child play with toys? If so, describe their play skills:

Potential Reinforcers: (i.e., if presented with a variety of options or given free time, what would your child choose)?

Communication Skills:

How does your child communicate his or her needs (please check all that apply)?

	Words	Signs	Gestures	Other
Request attention				
Ask for assistance				
Request toy/object				

Initiate activity				
Avoid a situation				
Take a break/stop				
Say “no” to request				
Indicate discomfort				

Receptive Communication: Is your child able to understand directions/ spoken language ?

Requests or instructions followed: No

Daily Living Skills: Describe your child’s ability to perform the following types of skills.

Self-care (e.g., dressing, toileting, bathing): Mom is needed for all self care tasks, sometimes yelling and uncooperative with self care tasks

Toileting: _____

Bathing: _____

Toothbrushing: _____

Handwashing: _____

Other: _____

Daily living (e.g., household chores): _____

Academics (e.g., writing, cutting): _____

Eating habits (e.g., self-feeding, utensil use, food variety): _____

Problem Behaviors:

What are your concerns about your child’s behavior? _____

Behaviors of Concern: What does your child say or do that concerns you most (e.g., aggression toward self or others, property destruction, tantrums, screaming, inappropriate interactions, resistance, off-task behavior, substance abuse, sexual behavior)? Estimate how often, long, and severe.

Behavior	Description (insert behavior below)	Frequency	Duration	Severity
1.		☐ hourly ____ ☐ daily ____ ☐ weekly ____ ☐ other:	30 seconds ____ minutes ____ hours (occasionally)	☐ high ☐ medium ☐ low
2.		☐ hourly ____ ☐ daily ____ ☐ weekly ____ ☐ other:	____ seconds ____ minutes ____ hours	☐ high ☐ medium ☐ low
3.		☐ hourly ____ ☐ daily ____ ☐ weekly ____	____ seconds ____ minutes ____ hours	☐ high ☐ medium ☐ low

		☐ other:		
4.		☐ hourly ____ ☐ daily ____ ☐ weekly ____ ☐ other:	____ seconds ____ minutes ____ hours	☐ high ☐ medium ☐ low
5.		☐ hourly ____ ☐ daily ____ ☐ weekly ____ ☐ other:	____ seconds ____ minutes ____ hours	☐ high ☐ medium ☐ low

In what environments do these behaviors occur? ☐ Home ☐ School ☐ Community ☐ Across all locations

Do the behaviors occur most likely when:

Situation	More Likely	No Impact	Less Likely	Notes
Asked to do a difficult task				
Told no or to stop activity				
Attention is withdrawn				
Change in routine/schedule				
Loud or chaotic situations				

Required to wait/delayed				
Transitions				
Other situations that are particularly difficult:				

Setting Events: List activities in which your child is most successful and those in which your child has the greatest difficulty.

Most Successful	Most Problematic
_____	_____
_____	_____
_____	_____

Impact of Behavior: How are your child’s behaviors affecting your child’s development, or participation in activities or settings? What is the impact on your family?

Additional comments:
