SPECTRUM LEARNING SOLUTIONS, LLC.
Solving the puzzle by thinking outside of the box

Initial Client Intake Form

Child's Name: ____________________________ Child's Date of Birth: ____________________

Sponsor's Name: _________________________ Sponsor's SSN: _____-_____-_____

Name of Referring Provider: ____

ECHO Enrolled: YES _____ NO_____

Mother's Name: ______________________________ Occupation: ____________________________

Home Phone: _______________________________ Mobile Phone: __________________________

Home Address: ____

Mother's Email Address: ____

Father's Name: ______________________________ Occupation: ____________________________

Home Phone: _______________________________ Mobile Phone: __________________________

Home Address: ____

Father's Email Address: ____

Diagnostic Information

Name of Initial Diagnosing Provider: ____

Diagnosis Received: __________________________________ Date Received: ___________________

Any Coexisting Diagnosis: YES (please describe) _________________________________ NO_______

Medications

Please list any use of psychotropic/psychiatric medicines: ☐ None ☐ Unknown

Current or Past?	Name of Medication	Condition	Dosage

Phone: (910) 803-2400 502 Highway 17N Holly Ridge, NC 28445 Fax: (910) 803-2401

Please list all people currently living in your child's primary home:

Name	Gender	Date of Birth/Age	Relationship

Is your child currently enrolled in school? YES ______ NO ______

Name of School: ____ Grade: ___________________

Type of Educational Setting (mainstream, resource room, self-contained, etc.):

____

Does your child have an IEP? YES ______ NO ______

Does your child receive any related services in school? YES ______ NO ______

If YES, please describe by service type, frequency, and duration of sessions:

____

____

____

Does your child receive any services outside of school? YES ______ NO ______

Type of Therapy	Provider/Agency	Frequency	Session Duration

Has your child ever received ABA services in the past? YES ______ NO ______

If YES, please describe *(date services began, date services ended, name of provider)*:

____

____

____

____

Child's Present Levels

Areas of Strength: ____
____
____
____

Areas of Concern: ____
____
____
____

Priorities for Treatment: ____
____
____
____

Are there any specific safety concerns in the home and/or community *(ex. elopement, PICA, running into the street, etc.)*? ____
____

Does your child have any medical conditions that we should be aware of prior to initiating treatment services (*ex. food allergies, seizures, asthma, etc.)*? ______________________________________
____

Applied Behavior Analytic treatment services are typically delivered in 2-hour sessions. If services are provided in our clinic setting, a parent or guardian does not need to be present for the duration of each session, however, they must be easily accessible by phone. If services are provided in the home, either a parent or guardian over the age of 18 must be present for the duration of each session.

Location Preference for Services: CLINIC ______ HOME ______

Child's Availability for ABA Treatment Sessions *(Days and Times)*:

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**

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