# Client Intake Form

This form is to be completed by the Parent/Guardian of the potential client of Stepping Stones ABA prior to the initial consultation visit. If you have not yet scheduled an initial consultation please contact us (901) 283-3486 or email steppingstonesaba.memphis@gmail.com to speak with a staff member.

You will need to bring the following additional information to the scheduled initial consultation.

1. Your child’s most recent IEP/BIP
2. Records of therapy (previous and current) for your child.
3. Diagnostic Information
4. Insurance Cards (if applicable)
5. Any documents related to services being received such as past intervention reports, or other relevant documents.

# Parent/Guardian Information

|  |  |
| --- | --- |
| **Parent/Guardian 1 Name: (First, Middle, Last)** |  |
| **Parent/Guardian 1 Email:** |  |
| **Parent/Guardian 1 Phone #:** |  |
| **Parent/Guardian 2 Name:****(First, Middle, Last)** |  |
| **Parent/Guardian 2 Email:** |  |
| **Parent/Guardian 2 Phone #:** |  |
| **Primary Street Address: (Street number)****(City, State, Zip)** |  |
| **Marital Status:** |  |

**Child’s Information**

|  |  |
| --- | --- |
| **Child’s Name (First, Middle, Last)** |  |
| **Child’s Date of Birth** |  |
| **Child’s Social Security** |  |
| **Primary Street Address (Street number)****(City, State, Zip)** |  |

**Insurance Information**

***A copy of the insurance card will be required at the time of initial visit***

Name of Primary Insurance Company:

Name of Policyholder:

Social Security # of Policy Holder:

DOB of Policy Holder:

Insurance Address:

Phone Number:

Member ID: Group ID:

Name of **Secondary** Insurance Company:

Name of Policyholder:

Social Security # of Policy Holder:

DOB of Policy Holder:

Insurance Address:

Phone Number:

Member ID: Group ID:

# Medical Information

Name of physician:

Physician address:

Physician phone: ( )

Does your child have any current health condition? If so, please explain below

Please list any medications that your child is currently taking.

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Frequency | Side effects |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Does your child currently have any diagnoses\*? If so, please state below.

\*Required for insurance coverage

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis | Diagnosing physician | Date diagnosed | Diagnosis Code |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Educational Information

Does your child attend school? If so, please complete the information below.

Name of school:

Classroom Type:

Teacher/Grade:

Address:

School Phone number: ( )

### Current/Previous Therapy Provider Information (please attach most recent evaluations): Behavioral Provider Name:

Contact Name/Phone:

Dates of Service:

Please state the therapy outcomes:

### Speech Therapy Provider Name:

Contact Name/Phone:

Dates of Service:

Please state the therapy outcomes:

### Occupational Therapy Provider Name:

Contact Name/Phone:

Dates of Service:

Please state the therapy outcomes:

### Other Therapy Provider Name:

Contact Name/Phone:

Dates of Service:

Please state the therapy outcomes:

### *Child’s Current Behaviors and Expected Outcomes:*

Please provide detail regarding the concerns of your child’s development, if any.

Please describe any problem behaviors or interfering behaviors of concern.

Please state the expectations/goals that you have for your child while engaging in a behavioral program:

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

\*Please attach any assessments or evaluations that may aid in developing your child’s program or behavioral interventions