Club Spectrum ABA
Orlando, FL
Phone: (407) 369-3788
coribonfilio@clubspectrumaba.com

INTAKE SCREENING FORM

Instructions:
Please complete and submit this screening form to schedule an appointment for an evaluation. You may submit this completed form to:

E-mail: referrals@clubspectrumaba.com

The following is a comprehensive list of what will need to be provided. Numbers 1-5 can be sent to BCBA via email before the initial meeting or given to BCBA in person. Numbers 6-7 can be addressed during the initial meeting.

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.
6. Any special accommodation your child may use, such as a chewy, weighted blanket, communication devices.
7. BCBA/BCaBCA will have additional questions regarding :
   - -Specific items your child is reinforced by
   - -Developmental history
   - -Sleep schedule
   - -Communication skills
   - -Adaptive skills (potty training)
   - -Problem Behaviors

Please answer to the best of your ability. If you do not know any answers, your Club Spectrum ABA Supervisor will work with you closely to determine if it is relevant information necessary for treatment.

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BIOGRAPHICAL

Child's Name: ___________________________________ **DOB:** ____________________

Sponsor ID/Insurance Subscriber ID: ____________________________

- **Caregiver/Legal Guardian #1**
  - *Name:*
    ____
  - *Address:*
    - ______________________
      ____
      ____
      ____
  - *Telephone:*
    - ______________________ (Cell)
    - ______________________ (Home)
    - ______________________ (Work)
  - *Email:* ______________________

- **Caregiver/Legal Guardian #2**
  - *Name:*
    ____
  - *Address:*
    - ______________________
      ____
      ____
      ____
  - *Telephone:*
    - ______________________ (Cell)
    - ______________________ (Home)
    - ______________________ (Work)
  - Email: ______________________

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- **Who Lives in the Home?** *(please include any pets so we can ensure proper employee placement for your home)*
  - ___________________________________
  - ___________________________________
  - ___________________________________
  - ___________________________________
  - ___________________________________

CURRENT MEDICAL/SCHOOL INFORMATION

- **Primary Care Physician:**
  - ____ *(Name/Affiliation)*
  - ____*(Address)*
  - ____*(Phone Number)*

- **School Information:**
  - ____*(Name of School/Teacher)*
  - ____*(Address)*
  - ____*(Phone Number)*
  - **Does your child have an active IEP? (YES / NO)**
  - **What grade level and placement setting does your child have at school? (i.e. EC Classroom, Gen. Education Setting, Resource)**
    - ____
  - **If permitted, ABA services can be provided in school for your child. This is based on district permissions and your child's specific needs. Are you looking to have school-based services in conjunction with home-based services for your child?**
    - **(YES / NO / Not Applicable)**

- **Other Service Providers (Speech/OT/etc.):**

Please include Facility, Names of Providers, and Contact Information

  - ____
  - ____
  - ____
  - ____

- **Medical/Behavioral History:**
  - **Autism Diagnostic Info:**
    - **Diagnosing Date (month/year):** ____
    - **Diagnosing Provider (name/credentials):** _________________________________
    - **Facility of Diagnosis (Name/State):** ____________________________________
    - **Level of Diagnosis (i.e. 1, 2, or 3):** ___________________________________
  - **Current Medications:** ____
  - **Allergies:** ____
  - **History of Seizures:** ____
  - **Any other Diagnoses (if none, please indicate):**

    ____

  - **Family History of Autism or related disorders (i.e. OCD, ADHD, etc.) If none, please indicate:**

    ____

    ____

    ____

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BEHAVIOR: Does your child have a history of **aggressive behavior** that can cause harm to self or others? If so, please provide a brief overview *(what it looks like, why it typically happens, and how often/how long the behavior can occur):*

- ____
  ____
  ____
  ____
- **If you answered "Yes," have there been any specific behavior interventions previously implemented for your child? (YES / NO / Not Applicable)**

MAIN AREAS OF CONCERN

- **What is your child's main form of communication? Please circle all that may apply:**
  - Verbally (with delays)
  - Verbally (age-appropriate)
  - Non-verbally (gestures only)
  - Communication Device
  - Picture Exchange (PECS)
  - Other:
    ____
    ____
    ____
    ____
- **In regard to receiving ABA services, what are your main areas of concern you would like to see an increase/decrease in with your child?**
  - ***Ex: Communication, Behavior, Independence Skills, Social Skills, etc.***
  - ____
    ____
    ____
- **Does your child have any sensory-related needs and/or aversions related to sights, smells, or sounds? (YES / NO)**

- **If you answered yes, please explain:**

  ____

  ____

- **Is there any other information important for Club Spectrum ABA to be aware of in relation to your child that could impact ABA services? (YES / NO)**
  - **If you answered yes, please explain:**

    ____

    ____

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PRIOR PROFESSIONAL CONTACTS

PLEASE LIST ALL PAST AND CURRENT THERAPIES YOUR CHILD HAS RECEIVED BY COMPLETING THE BOXES BELOW

Service *(Please circle the services received)*	**Start/End Date (Month/Year)**	**How Often?** *(times per week/month)*	**Length of Sessions** *(In Minutes/hrs.)*	**Main Targeted Goals**	**Effect of Therapy** *(WORSE, NO CHANGE, IMPROVED)*	**Contact Information**
Occupational Therapy						
Physical Therapy						
Speech						
Early Intervention						
Other (Please indicate):						

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CHILD AVAILABILITY FOR THERAPY SESSIONS

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00 AM					
9:00 AM					
10:00 AM					
11:00 AM					
12:00 PM					
1:00 PM					
2:00 PM					
3:00 PM					
4:00 PM					
5:00 PM					
6:00 PM					