Behavioral ONE
Assessment | Treatment | Support

New Client Enrollment Information

IDENTIFYING INFORMATION

Client's Name:_____DOB:_____

Address:_____

Mother's Name:_____DOB:_____

Father's Name:_____DOB:_____

CONTACT INFORMATION

	Phone Numbers	Email Address
Mother		
Father		
Guardian		
Other		

FAMILY INSURANCE INFORMATION

Please attach a copy of the front and back of your insurance card and license

Primary Insurance Provider:_____

Policy Holder Name: _____ DOB: _____

Member ID: _____ Group #: _____

Billing Address: _____

Employer: _____

Pediatrician: _____ Phone Number: _____

Secondary Insurance Provider: _____

Policy Holder Name: _____ DOB: _____

Member ID: _____ Group #: _____

Billing Address: _____

Employer: _____

BACKGROUND INFORMATION

Does your child have an Individualized Education Plan (IEP)? **If so, please provide a copy of the IEP.**

Does your child have a medical diagnosis of Autism Spectrum Disorder by a Licensed Psychologist? Who made the diagnosis and when was it made? **If so, please provide a copy of the report.**

MEDICAL TREATMENT HISTORY

Please provide the following information regarding any specialists who have evaluated and/or treated your child:

Type of Service Provider	*Agency/Provider Name*	*Agency/Provider Complete Address*	*Dates Seen*
Hospitalizations			
Pediatrician			
Family Physician			
Neurologist			
Psychiatrist			
Psychologist			
Eye Specialist			
ABA Services			
Speech/Language			
Occupational Therapist			
Geneticist			
Children's Rehab Service			
Public Health Dept.			
Dept. of Human Resource			
Others:			
Others:			

If you child has been seen for previous therapies, please give a brief description of their response to these interventions:

PRENATAL AND BIRTH HISTORY

	Response	*Notes and Description*
Length of Pregnancy		
General Condition		

DEVELOPMENTAL HISTORY

Provide the approximate ages at which your child began to reach the following developmental milestones. You may use early, late, or on time if age is unknown.

Milestones	*Age Occurred*	*Notes*
Smile		
Coo/Babble		
Roll Over		
Sit Alone		
Single Words		
Phrases		
Short Sentences		
Crawl		
Stand Alone		
Walk Alone		
Feeds Self		
Dresses Self		
Toilet Trained – Bladder		
Toilet Trained – Bowel		
Toilet Trained – Night Time		

Additional Information:_____

How does your child communicate? Please check all that apply.

Communication Style	*Check all that apply*	*Notes*
Crying		
Playful Sounds		
Pointing with Index Finger		
Words		
Phrases		
Sentences		
Sign Language		
Picture Communication		
Communication Device		
Problem Behavior		

How much of your child's speech is understandable to you? Some_____Most_____All_____

How much of your child's speech is understandable to others? Some_____Most_____All_____

Does your child exhibit difficulty with the following?
Understanding what someone says: Yes☐No____
Talking: Yes☐No____

Please answer the following questions about your child's motor coordination.

Motor Area	*Concerns?*	*Notes*
Walking		
Running		
Gross Motor Coordination		
Fine Motor Activities		
Playground Activities		
Hand Preference	Right / Left / Both / Unsure	

How would you describe your child? Please check all that apply:

	Usually very active		Sometimes active, but can play quietly
	Usually not active		Unusually happy compared to others
	Unusually sad compared to others		Can be moody
	Demands attention (peers or adults)		Aggressive towards self or others
	Difficulty attending to activities		Prefers motor activities
	Prefers sit-down activities		Other:

FEEDING

Weight:_____

Feeding Method (circle): Bottle Fed / Baby Food / Table Food / Special Diet

Are there or have there been any feeding problems? If yes, please describe:_____

Do you consider your child a picky eater? If yes, what foods will he/she eat?_____

Does your child drool more than others? _____

Is your child on any special diet or take any nutritional supplements? If yes, please describe:_____

Are you interested in feeding therapy for your child? _____

SENSORY

Is your child…

	Oversensitive or reactive to sound		Doesn't like having things on his/her hands
	Under sensitive or reactive to sound		Sensitive to certain types of clothing
	Over sensitive or reactive to light		Always having to touch different fabrics
	Under sensitive or reactive to light		Smells things you would not expect
	Picky eater		Overstuffs mouth with food
	Over sensitive to pain		Avoids movement activities
	Under sensitive to pain		Seeks movement activities

BEHAVIOR

Does your child engage in problem behavior? If yes, please describe:_____

Why do you think he/she engages in the problem behavior?_____

What do you do immediately following your child's problem behavior?_____

PLAY SKILLS

Please describe your child's independent play skills:_____

Please describe your child's play skills with other peers:_____

INTERESTS

What are your child's interests? _____

What motivates your child?_____

COMMUNITY INTEGRATION

What activities is your child involved in outside of school/therapy hours?_____

Are you and/or your child involved in any Autism Spectrum Disorder support groups outside of school/therapy?

GOALS OF THERAPY

Please list three communication related goals you would like for your child to accomplish this year?

1._____

2._____

3._____

Please list three motor skills or daily task goals that you would like your child to accomplish this year?

1._____

2._____

3._____

Self-Help Checklist

Can your child? Does your child?	Yes/No	Provide any additional comments or feedback
Cooperate with dressing (holds out arms and feet)		
Push arms through sleeves and legs through pants		
Push down/pull up pants		
Pull off socks and shoes		
Put on socks and shoes (without tying)		
Identify front/back of clothing		
Remove/put on pullover garment independently		
Snap or button fasteners on clothing		
Tie shoes		
Dress unsupervised		
Toilet trained		
Complete toilet hygiene independently		
Wash and dry hands		
Brush teeth		
Brush hair		
Bathe		
Wash hair/face		
Drink from open cup		

Finger feed		
Use a spoon/fork to feed		

Regarding self-help skills, please list any additional comments:
_____
_____
_____

Medical Information

List child's medications (name and reason for taking the medication):

Does your child have any allergies (drug or food)? If yes, please provide a copy of your child's Allergy & Anaphylaxis Emergency Care Plan or another written emergency care plan:

Does your child have a specific medical diagnosis or significant health problem?