CREATIVE BEHAVIORAL CONNECTIONS
creating connections to last a lifetime

5803 W. Craig Road, Suite 105, Las Vegas, NV 89130
Phone: 702-901-5200 Fax: 702-901-5201

Registration Form

CLIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____

_____

Home Phone:_____ Cell Phone:_____

Gender:_____ Clients School & Grade:_____

Mother's Name:_____ Father's name:_____

Parent's marital status: □ Married □ Divorced □ Separated Custodial Parent:_____

Whom may we thank for referring you?_____

In case of emergency who should we notify?_____

INSURANCE INFORMATION

Person Responsible for Account:_____

Relationship to Client:_____ Date of Birth:_____

SSN:_____ Employer:_____

Insurance Company:_____ Subscriber #:_____

Group #:_____ Phone #:_____

Insurance Address:_____

Is the client covered under additional insurance? □ Yes □No. If yes, Subscribers Name:_____

Relationship to Client:_____ Date of Birth:_____

SSN:_____ Occupation:_____

Insurance Company:_____ Subscriber #:_____

Group #:_____ Phone #:_____

Insurance Address:_____

_____ _____

Client's Name Date

_____ _____

Signature of Client/Parent/Legal Guardian Relationship

TREATMENT SERVICES AGREEMENT AND CONSENT FORM

Welcome to Creative Behavioral Connections (CBC). This document contains important information about our professional services and business practices. Please read this document carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and CBC.

SERVICES OFFERED

CBC is dedicated to creating and maintaining a collaborative treatment approach with the client and their families, focusing on evidenced based and scientifically validated assessment and treatment services. CBC understands every client is unique with differing circumstances. Given this, we work with you and your family to identify goals consistent with individual and family needs.

CBC provides a range of services, including diagnostic evaluations, behavioral assessments, and individual and group treatment services. The ABA treatment services include individual focused and comprehensive applied behavioral treatment, and group social skills.

Diagnostic Evaluations: Diagnostic evaluations may include some or all the following:

- Assessment of Autism Spectrum Disorders symptoms and behaviors
- Assessment of Intellectual Abilities
- Assessment of Executive Functioning
- Assessment of Language Fundamentals
- Assessment of Adaptive Functioning
- Assessment of Achievement
- Assessment of Behavioral and Emotional Functioning

- During the evaluation, the evaluator will gather information including a developmental history, conduct psychological testing, and observe the individual being tested. At the end of the diagnostic evaluation, a comprehensive report will be developed, including a diagnosis, summary of the strengths and weaknesses identified in the evaluation process, and treatment recommendations.

Behavioral Assessments: Behavioral assessments are concerned with deficits in specific skill areas that may be contributing to problem behaviors, and generally assess some or all the following:

- Language
- Cognitive skills
- Social skills
- Adaptive functioning
- Self-help skills

- During the assessment process, direct observation will be essential for the evaluation of environmental variables that may be maintaining or increasing the behavior. Behavioral assessments define the problem behaviors and function the behavior serves. At the conclusion of the behavioral assessment, an individualized assessment report is completed, and a Positive Behavioral Support Plan (PBSP) is developed.

Focused ABA Treatment: The goal of Focused ABA treatment is to address a limited number of target behaviors. Focused treatment focuses on compliance within specific settings (home, school), self-help skills, social skills, adaptive skills, academic remediation, and daily living skills, and can range from 5 to 25 hours a week.

Comprehensive ABA Treatment: The goal of comprehensive ABA treatment is to maximize independence in multiple skill areas and/or improve the individual's functioning to levels typical for his or her chronological age. Initially, comprehensive treatment involves structured one-on-one therapy, and can range from 26 to 40 hours a week; however, as the individual gains skills, more naturalistic and small group settings may be incorporated.

A PBSP, which outlines the function of the target behaviors, will be developed for all clients receiving ABA treatment services. The duration and intensity of treatment is based on the individual needs and severity of the behaviors. Treatment decisions are based on data collection, and reassessment occurs periodically throughout the duration of treatment. Family involvement and family education on specific principles and procedures of ABA is provided on an on-going basis.

We also provide mental health services, including intake evaluations and individual therapy, couple, and family therapy for an array of presenting problems and mental health disorders.

ASSESSMENT, PREPARATION, AND PARTICIPATION

When a diagnostic evaluation or behavioral assessment is being conducted, it is important for the individual to perform their best. Please inform the evaluator if there have been any recent changes in behaviors, medications, diet, sleep routine, or if there has been any significant illness that may impact performance on testing. The length of a diagnostic evaluation can vary depending on the assessment instruments used, and can exceed 8 hours in some situations. Given this, it is important the individual being assessed has had adequate rest and nutrition prior to being assessed.

Parent/caregivers participation is an expectation of service. Participation may include data collection, implementation of recommended strategies, and team meetings. Team meetings will focus on monitoring progress to determine appropriate level of services needed, and any barriers to treatment. Lack of involvement of parent/caregiver may result in termination from services.

APPOINTMENTS

CBC staff is committed to providing consistent and reliable service as scheduled. A preliminary set of hours will be identified based on the results of the assessment and consideration of medical necessity. A weekly or monthly schedule of services will be defined between the client/family and service providers assigned to the case. Any party may cancel or reschedule sessions previously scheduled at no cost to the client.

CBC understands there are circumstances that arise, such as illness or family emergencies, which necessitate the cancellation of appointments. To avoid any misunderstandings, CBC requests the client/ family send an email to support@cbcautism.com. Excessive cancellations may result in termination of services, as consistency is critical for treatment success. If you need to cancel, CBC asks you give as much advanced notice as possible, as will the CBC service providers.

COMMUNICATION

CBC understands the importance of open communication and is committed to responding to your questions and comments in a timely manner. The treatment providers are committed to providing quality services, which includes timely and professional communication. Clients will be provided with telephone

numbers and email addresses of those individuals who will be directly involved in their care. If you have basic questions about CBC or ABA therapy, you are welcome to send an email to info@cbcautism.com.

CBC does not provide on-call coverage 24 hours per day, 7 days per week. In the event of an emergency, please contact your physician or call 911 and/or go to the nearest hospital emergency room.

Clients may contact their treatment providers with questions or comments by telephone or email. Concerns can be directed to CBC's CEO, Dr. Michelle McGuire, at mmcguire@cbcautism.com or 702-901-5200.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

CBC is required to adhere to the Federal Health Insurance Portability and Accountability Act (HIPAA), when using and disclosing Protected Health Information (PHI). The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations, and other specified purposes as outlined in CBC's Notice of Privacy Policy. If you request information to be shared with other treatment providers, you will first need to sign a written Authorization to Release Protected Health Information specifying what information can be released and to whom it can be shared.

There are times when state laws may require the disclosure of confidential information without expressed written permission under certain circumstances. These circumstances include: if a person is in danger of hurting themselves or someone else; child abuse, elder abuse, or abuse of a vulnerable adult is suspected; or if court ordered. CBC staff routinely consults with other professionals. In doing so, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them.

FEES AND HEALTHCARE INSURANCE INFORMATION

The following fee schedule represents the fee-for-service rates as of January 1, 2023:

Diagnostic Evaluation:	$2,500.00
Behavioral Assessment:	$700.00
Re-assessment:	$300.00
ABA Treatment Services:	
• BCBA:	$225.00 per hour
• BCaBA:	$175.00 per hour
• RBT:	$125.00 per hour
Group Treatment Services:	$50.00 per group
Parent Training:	$125.00 per hour
Intake Evaluation:	$250.00
Individual Therapy:	$200.00
Couples or Family Therapy:	$250.00
Psychological Testing:	$200.00 per hour

Payment for all treatment services is due at the time of the service, unless other arrangements have been made. If your insurance carrier provides financial assistance for treatment services, and CBC is a contracted provider for your insurance, CBC will discuss the procedures for billing your insurance carrier. The amount of reimbursement and the amount of any co-payments or deductible depends on the

requirements of your specific insurance plan. You should also be aware you are responsible for verifying and understanding the limits of your insurance coverage.

You understand you are financially responsible for all charges whether or not paid by your insurance. In the event your account becomes past due, your balance will accrue interest at the rate of 1% per month (i.e. 12% per annum). A past due account is an account not paid within 30 days from our 1st date of billing you. In the event that you fail to pay in full or make any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill, (or we are unable to locate/notify you of your account status despite reasonable effort) your balance will be turned over to our outside office Collection Agency. A $50 charge will be assessed to all collection's accounts, in addition to any accrued interest. If your account is referred to our Collection Agency, interest will continue to accrue at the rate noted herein. In addition, you will be responsible for all added percentage-based Collection fees/costs per our prevailing collection company contract, Attorney fees, Court Costs, Administrative/Service Fees & associated Miscellaneous Fees and Costs. You authorize said assignee to release all necessary information to secure the payment of said benefits.

INFORMED CONSENT FOR SERVICES

Your signature below indicates you have received and read the information in this document. Consent by all parents/legal guardians is required prior to evaluations, assessments, or treatment services being provided to minor children.

These policies have been fully explained to me and I fully and freely give my consent for services to be provided.

_____ _____

Client's Name/Attestation Signature Date

_____ _____

Client/Parent/Legal Guardian Signature Date

_____ _____

CBC Representative Date

LEGAL CUSTODY

Client Name:_____ Date of Birth:_____

I, the undersigned, indicate by my signature below, I have legal custody of the child (named above), and, therefore, have the right to seek evaluation and/or treatment for this child. I have been advised by Creative Behavioral Connections it is their recommendation my child's other parent, if any, be informed of my decision to seek evaluation and/or treatment.

SIGNATURES

_____

Printed Name - Parent or Legal Guardian

_____ _____

Signature Date

_____ _____

CBC Representative Date

CLIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

- Considerate and respectful care and to be comfortable in the environment in which your care is provided.
- Receive care in a safe setting, free from verbal or physical abuse or harassment.
- Receive information about you or your child's evaluation and/or treatment status, course of treatment, and outcomes of treatment in terms you can understand.
- Participate actively in decisions regarding you or your child's evaluation and/or treatment and to receive as much information about your proposed evaluation and/or treatment as you may need to give informed consent or to refuse a course of treatment.
- Be advised if the provider proposes to engage in or perform research affecting you or your child's treatment. You have the right to refuse to participate in such research projects and your decisions will not affect your right to receive care.
- An estimated cost of you or your child's evaluation and/or treatment.
- Reasonable responses to any reasonable requests made for evaluation and/or treatment services.
- Have personal privacy respected. Case discussions, consultations, and other evaluation and/ or treatment services are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. Written authorization shall be obtained before medical records are made available to anyone not directly concerned with you or your child's care, except as otherwise required by law. You have the right to access information contained in you or your child's records within a reasonable time frame, except in certain circumstances specified by law.
- Receive a written "Notice of Privacy Practices" explaining how your Protected Health Information (PHI) will be used and disclosed.
- Receive reasonable continuity of care and know in advance the time of your appointments as well as the identity of the person providing the care.
- Exercise these rights without regard to age, disability, gender, gender identity or expression, sexual orientation, economic status, educational background, race, color, religion, ancestry, national origin, marital status, or source of payment.

You have the responsibility to:

- Follow Creative Behavioral Connections (CBC) rules and regulations affecting care and conduct. This includes the following:
    - Show respect for the rights and privacy of other clients and their families while in the waiting room and other areas of the clinic. ALL clients are entitled to a private, quiet, therapeutic atmosphere. This includes monitoring the behavior of all children you may bring with you to appointments as well as the individual who is a client of CBC while in the reception area.
    - Complete any intake paperwork provided to you prior to your first scheduled appointment or the appointment may be rescheduled.
    - Report, to the best of your knowledge, accurate and complete information regarding any matters pertaining to your child's condition or payment information and insurance information.
    - Unless actively participating in a session or meeting with your child's provider, please remain in the waiting room area. You should not leave the clinic while your child is receiving an evaluation and/or treatment unless arrangements have been made prior and approved by the CEO.

- Use of cell phones is prohibited in the clinical area of the clinic. Please turn off your cell phone prior to entering the clinical area. Should you choose to use your cell phone during a session, you will be asked to return to the reception are for the remainder of your child's session.
- Comply with all posted rules and regulations while in the clinic.
- Be considerate of all CBC facilities and equipment and use them in a manner as to not abuse or destroy.
- Arrive on time for all appointments. If you are up to 15 minutes late, you will be seen, but the appointment will end at the scheduled time. If you are more than 15 minutes late, the appointment will be rescheduled.
- Be respectful of your provider's time. Please provide the most advanced notice of a cancellation as possible. Failure to provide notice may result in the assessment of fees.
- Continuity of care is critical to success. If you cancel more than five appointments in a two-month period, CBC staff will meet with you to discuss your child's attendance and make appropriate adjustments to the schedule, which may include a reduction in the number of scheduled appointments.
- If you fail to call to cancel an appointment more than two times, a written notice will be sent, and your child may be removed from the schedule.
- Payment is expected at the time services are rendered unless prior arrangements have been made.
- Follow the treatment plan recommended by your child's providers. It is your responsibility to tell your service providers whether or not you can and want to follow the treatment plan recommended for your child. The most effective plan is the one which all participants agree is the best and which is carried out exactly.

ACKNOWLEDGEMENT

By signing this form, you acknowledge you have read, understood, and agree to comply with the above Client Rights and Responsibilities. You may request a copy of this document for your records.

If you have any questions about the Client Rights and Responsibilities, please contact our front office at 702-901-5200.

_____

Printed Name of Client

_____ Date: _____

Signature of Client (or Client's Parent/Legal Guardian)

_____ Date: _____

CBC Representative

NOTICE OF PRIVACY PRACTICE

This notice describes how your Protected Health Information (PHI) may be used and disclosed by Creative Behavioral Connections (CBC) and how you can obtain access to this information. Please review this information carefully.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where, and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep records of your symptoms, examinations, test results, diagnosis, treatment plans, progress notes, and other medical information. We also may obtain health records from other providers. In using and disclosing this PHI we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA), 45CFR, Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations, and other specific purposes explained in this notice. This includes contacting you for appointment reminders and follow-up care.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

- Request a restriction of the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer at CBC. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of $.60 per page and the actual cost of postage per **NRS 629.061,** except you are not entitled to access to, or to obtain a copy of psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the request amendment.
- Obtain an accounting of disclosures of your PHI, except we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorizations, among other exceptions.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, email, fax, and/or telephone.
- Revoke authorization to use or disclose PHI at any time except when action has already taken place.

OUR RESPONSIBILITIES

The law requires us to:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.

- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practices and will apply the change to all your PHI, including information obtained prior to the change.
- Post notice of any changes in our Privacy Policy in the lobby and make a copy available to you upon your request.
- Use or disclose your PHI only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your PHI.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

You may contact the designated Privacy Officer, Linda Stevens, Quality Assurance Manager, 5803 W. Craig Road, Suite 105, Las Vegas, NV 89130, 702-901-5200. If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

DISCLOSURES OF PHI

We may use or disclose your PHI for treatment, payment, and operation, and for purposes described below:

- **Treatment:** We will use and exchange information obtained by a physician, nurse practitioner, psychologist, or other health professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become a part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as determined necessary for your care. For example, we may disclose your PHI to an outside doctor for referral. We may also provide your health care providers with copies of various reports to assist them in your treatment.
- **Payment:** We will send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as the portion of your PHI necessary to obtain payment.
- **Health Care Operations:** Members of the staff, trainees, students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care to improve the quality of the care and services we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors, or attorneys may be required to review your health information to meet their responsibilities.
- **Other uses and disclosures not requiring authorization:**
    - **Business Associates**: There are some services provided to our organization through contracts with business associates. We may disclose your PHI to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
    - **Notifications**: We may disclose limited PHI information to friends and family identified by you as being involved in your care of assisting you with payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
    - **Legally Required Disclosures, Public Health, & Law Enforcement**: We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state

law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, though in such circumstance you will not be personally identified), to an employer to evaluate whether an employee has a work related injury, and to public officials to report births and deaths. We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.

- **Information Regarding Decedents**: We may disclose PHI regarding a deceased person to: 1) Coroners and Medical Examiners to identify cause of death or other duties; 2) Funeral Directors for their required duties; and 3) to procurement organizations for purposes of organ and tissue donation.
- **Research**: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure that privacy of your PHI. In all other situations, we may only disclose PHI for research purposes with your authorization.

- **Disclosures Requiring Authorization:** All other disclosures of PHI will only be made pursuant to your written authorization; which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.

ACKNOWLEDGEMENT

_____

Client's Name- Please Print

By signing this form, you acknowledge receipt of this Notice of Privacy Practice. Our Notice of Privacy Practice provides information about how we may use and disclose your PHI. We encourage you to read this information in full.

If you have any questions about our Privacy Practices, please contact our front office at 702-901-5200.

_____ _____

Client, Parent/Legal Guardian Signature Date

_____

Print Name

_____

Relationship to Client

CONSENT TO USE ELECTRONIC COMMUNICATION

Risks to confidentiality and privacy: The treatment providers cannot ensure the confidentiality of any form of communication through electronic media or guarantee absolute protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically. Email, e-faxes, and texts may be sent erroneously to the wrong address. Backup copies of emails and texts may exist even after the sender and/or recipient has deleted the correspondence. Employers and online services have a right to inspect emails sent through their company systems. E-mails and text messages can be used as evidence in court.

CONSENT

I have been advised of the risks of using electronic communication and I consent to the use of the following (please initial):

_____Email: Address:_____

_____Texting: Number(s):_____

_____Fax: Number:_____

Additionally, CBC treatment providers can use the following means by which to contact me, and or leave a message:

_____Home Phone:_____ _____Work Phone:_____

_____ _____
Client's Name Date

_____ _____
Parent/Legal Guardian (if applicable) Date

_____ _____
CBC Representative Date

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By completing this form, I, or my legal representative, agree to allow the sharing of my Protected Health Information (PHI) with the people or agencies identified below.

Client's Name:_____ Date of Birth:_____
Address:_____
Phone Number:_____ Social Security Number:_____

I request and authorize the release of healthcare information of the above named client:

Send Records □ TO □ FROM:	**Send Records □ TO □ FROM:**
Creative Behavioral Connections 5803 W. Craig Road, Suite 105 Las Vegas, NV 89130 P: 702-901-5200 F: 702-901-5201	Name:_____ Address:_____ _____ Phone:_____Fax:_____

Purpose of Release:

□ Treatment/ Continued Care □ Personal Use □ Legal □ Disability Determination □ School
□ Other:_____

Information To Be Released:

□ Entire Record □ History and Physical □ Psychological Evaluation □ Psychiatric Evaluation
□ Progress Notes □ Discharge Summary □ Immunization Records □ Past/Present Medication
□ Other (Specify):_____
Your initials are required to release the following information:
_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Results/Treatment

Effective Time Period: This authorization is valid until the earlier of the occurrence of death to the individual; the individual reaches the age of majority; or permission is withdrawn; or the following specific date:_____.

Right to Revoke: I understand that I can withdraw my authorization at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Send Records To". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my PHI will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information described. I understand that refusing to sign this form does not stop disclosures of PHI that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 CFR 164.502. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
Client, Parent/Legal Guardian Signature Date

_____ _____
Print Name Relationship to Client

Neuropsychological and Developmental History

CLIENT INFORMATION

Name:_____ Today's Date:_____

Date of Birth (Age):_____( ) Handedness: □ Right □ Left □ Ambidextrous

Primary Language:_____ Sexual Orientation:_____

Sex assigned at birth: □ Male □ Female Pronouns: □ he/him □ she/her □ they/them

Current Grade:_____ School:_____

Race/Ethnicity:_____ Spirituality:_____

Are there any disability needs? □ No □ Yes:_____

Who referred you?_____

Name of person completing this questionnaire/ relationship:_____

REFERRAL INFORMATION

Please describe the symptoms or problems that are of most concern to client:_____

_____

_____

When did these problems start?_____

_____

Have they gotten worse over time? Please describe:_____

_____

In your opinion, what are the major causes of the difficulties?_____

_____

Describe client's strengths:_____

_____

Describe some of client's weaker areas:_____

_____

Has the client had a psychological evaluation before? □ No □ Yes, Dates:_____

Psychologist:_____

Tests given:_____

_____

Outcomes/Diagnosis:_____

Are you willing to sign a release? □ No □ Yes

Is this evaluation subject to litigation of any kind? □ No □ Yes:_____

FAMILY INFORMATION

Parents:

Mother's name:_____ Age:_____

Highest Education:_____ Occupation:_____

Father's name:_____ Age:_____

Highest Education:_____ Occupation:_____

Parents are: □ married □ separated □ remarried □ deceased

□ divorced (custody arrangements:_____)

Child is: □ biological □ adopted (at age:_____) □ foster (since age:_____)

Siblings: (names/age):_____

_____

How does the client get along with them?_____ _____

Others living in the home (names, ages, relationship):_____

_____

Childcare arrangements (if needed: what type? Hours/days?)_____

_____

Has the client experienced death or separation from a loved one? Describe:_____

_____

Are there any significant family or marital conflicts? Explain:_____

_____

Are there any current or previous legal issues in the family? □ No □ Yes:_____

PREGNANCY AND BIRTH HISTORY

Age of Mother _____ and father _____ at client's delivery.

How many prior pregnancies?_____ How many prior miscarriages?_____ Fertility Specialist consulted?

□ No □ Yes, which procedure:_____

Known health problems of mother during pregnancy: □ Vaginal Bleeding □ Toxemia □ Trauma

□ Hypertension □ Gestational Diabetes □ Fever/Rash □ Blood incompatibility □ Injury

□ Other:_____

Did mother use tobacco during pregnancy? □ No □ Yes, how often?_____

Was there tobacco use in the home?_ □ No □ Yes, how often?_____

Did mother drink alcohol during pregnancy? □ No □ Yes, how often?_____

Did mother use illegal substances during pregnancy? □ No □ Yes, (what, how much, how often)?_____

_____

List any medications used during pregnancy and frequency:_____

Delivery was: □ Vaginal □ Cesarean (reason_____)

Labor was: □ Spontaneous □ Induced □ Easy □ Moderate □ Hard

Baby was: □ Full term □ Premature (_____ weeks gestation)

Birth weight: _____ pounds _____ ounces

Was labor prolonged? □ No □ Yes, how long?_____

Were forceps used during delivery? □ No □ Yes:

Any birth complications: □ cord around neck □ meconium staining □ lack of oxygen/blue □ feet first

□ jaundice/yellow Describe:_____

Did baby breath spontaneously? □ No □ Yes Oxygen required? □ No □ Yes:_____

Other interventions required? □ No □ Yes, explain:_____

In intensive care nursery? □ No □ Yes, length of stay?_____

How old was the baby at discharge from the hospital?_____

Medical problems at discharge?_____

_____

List any problems in the first few months of life:_____

_____

Did mother experience any postpartum depression? □ No □ Yes, interventions?_____

DEVELOPMENTAL HISTORY

Motor

Age sat alone:_____ crawled:_____ stood alone:_____ walked alone:_____

Was child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, riding a bike, playing ball)? □ No □ Yes, explain?_____

How is the child's handwriting?_____

Was physical or occupational therapy ever recommended? □ No □ Yes, length:_____

Any current motor or coordination issues:_____

Speech/Language

Age child spoke first word: _____ put 2-3 words together:_____

Speech delays or problems (e.g., stuttering or articulation problems)? □ No □ Yes, describe:_____

_____

Was speech therapy ever recommended/pursued? □ No □ Yes, length:_____

Was the child slow to learn the alphabet? □ Yes □ No

Was the child slow to learn the names of colors? □ Yes □ No

Was the child slow to learn to count? □ Yes □ No

Other languages spoken in the home, besides English:_____

Language child speaks with parents:_____ siblings:_____ friends:_____

Toileting

Age when toilet trained:_____ Did the child ever have: □ problems with bedwetting

□ urine accidents □ soiling/fecal accidents If yes, at what age:_____

Any current problems with toileting?_____

Adaptive

As an infant, to a significant degree, were any of the following present during the first two years of life?

□ Did not enjoy cuddling □ Was not calmed by being held or stroked □ Difficult to comfort

□ Colic □ Excessive restlessness □ Poor sleep □ Head banging □ Difficulty nursing

COGNITIVE, EMOTIONAL AND BEHAVIORAL FUNCTIONING

Has the client ever showed the following? Describe:

□ Problem solving difficulties _____

□ Concentration difficulties _____

□ Memory impairment _____

□ Sensory issues _____

□ Frequent crying _____

□ Irritability _____

□ Distractibility _____

□ Apathy/Lack of interest _____

□ Temper tantrums _____

□ Mood swings _____

□ Aggression _____

□ Self-injurious behaviors _____

□ Destructive behaviors _____

□ Anxiety/tension _____

□ Fearfulness _____

□ Repetitive behaviors _____

□ Repetitive thoughts _____

□ Fatigue _____

□ Changes in eating or sleeping _____

□ Nightmares _____

□ Increased suspiciousness _____

□ Unusual thoughts _____

□ Hallucinations _____

□ Daydreaming _____

□ Impulsivity _____

□ Restlessness/Hyperactivity _____

□ Low frustration tolerance _____

□ Forgetting _____

□ Suicidal thoughts _____

□ Personality changes _____

□ Legal difficulties _____

□ Tobacco/alcohol use _____

□ Other substance use _____

How does the client get along well with: Peers:_____

Adults:_____

Does the client have friends?_____ Keep friends?_____ Understand gestures?_____

Understand jokes?_____ Have a good sense of humor?_____ Understand social cues?_____

Have problems with peer pressure?_____ Get taken advantage of by others?_____

How many friends does the client have? How old are their friends?_____

_____

What does the client like to do for fun?_____

_____

What extracurricular activities is the child involved in?_____

_____

MEDICAL HISTORY

Has the client's vision been checked? □ Yes □ No Problems?_____

Has the client's hearing been checked? □ Yes □ No Problems?_____

Does the child have allergies to food/medications? □ No □ Yes:_____

Adverse reactions:_____

Primary Care Physician:_____Sign a release? □ Yes □ No

Previous and Current health conditions/ medical issues:

Dates	Providers	Treatment/Outcomes

Please list all surgeries/hospitalizations (use additional paper if necessary):

Dates	Reasons	Treatment/ Outcomes

Has the client ever had a head injury with loss of consciousness or feeling of being "dazed"? □ Yes □ No

Type of head injury	Date	Loss of consciousness	Outcome

Please list all current medications:

Medication	Amount	Reason

***Family history**:*

Is there a history of learning disabilities? □ No □ Yes, describe:_____

Is there a history of social problems? □ No □ Yes, describe:_____

Is there a history of neurological illness? □ No □ Yes, describe:_____

Is there a history of psychiatric disorders? □ No □ Yes, describe:_____

Is there a history of addiction/gambling? □ No □ Yes, describe:_____

Does anyone in the family have a problem similar to the client?_____

EDUCATIONAL HISTORY

Does the client have an IEP or 504 Plan: □ No □ Yes, category:_____

Are you willing to provide a copy of the IEP? □ Yes □ No, reason:_____

Placement: □ regular classroom □ resource support □ self-contained classroom □ speech/OT/PT
□ alternative school setting

Any grades repeated: □ No □ Yes, which grades/reason:_____

Any grades skipped: □ No □ Yes, which grades/reason:_____

Teachers report problems in: □ reading □ spelling □ math □ writing □ attention/concentration
□ socialization □ behaviors:_____

Any other academic or school problems? Please explain:_____

_____

Current letter grades:_____

Have teachers reported problems that are not evident at home? If so, what are they?_____

_____

_____

INTERVENTION HISTORY

Has the client been seen by another ABA agency, psychologist, psychiatrist, or clinic? □ No □ Yes:

Dates	Providers	Treatment/ Outcomes

Would you be willing to sign a release? □ Yes □ No, reason: _____

Are you engaged with any community supports (Support groups, social services?) □ No □ Yes:_____

_____

Please add any other comments that you feel are important for us to know:_____

_____

_____

_____

_____

_____

Parent's Signature Date