COLLABORATIVE CARE
Behavioral Therapy
LLC

CLIENT INTAKE FORM

****Along with this form, please send any documentation from the Autism Diagnosis and Supplemental Documentation,(*i.e., ADIR, ADOS, CARS, GARS)* if your referring physician did not already do so.**

Child/Client Information

Last Name:		First Name:	MI:
Age: years months		Date of Birth:	
Street Address:			
City:	State:	Zip:	County:
Primary Diagnosis:		Diagnosing Physician:	
Date of Diagnosis:			
Secondary Diagnosis:		Diagnosing Physician:	
Date of Diagnosis:	Referring Physician:		
Other Behavioral Conditions: *Include date of diagnosis and any information you think we would find helpful in the child or client's treatment.*			
School Attending:		Years Attended:	Grade/Placement:
School Contact Person:		Contact Phone:	
Current IEP? ☐ Yes ☐ No **(if yes, please attach current ETR and IEP)**		Can CCBT Contact School? ☐Yes ☐No	

Mother or Legal Guardian Information

Full Name:		Relationship to Child:	
Street Address:			
City:	State:	Zip:	County:
Occupation:		Employer:	
Home Phone:		Cell Phone:	
Work Phone:		E-mail:	
Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail			

Father or Legal Guardian Information

Full Name:		Relationship to Child:	
Street Address:			
City:	State:	Zip:	County:
Occupation:		Employer:	
Home Phone:		Cell Phone:	
Work Phone:		E-mail:	
Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail			

Client Family Members

Include all who reside in the home with the child.

Parent/Guardian 1:	Age:	Sex:		Relationship:
Parent/Guardian 2:	Age:	Sex:		Relationship:
Name:	Age:	Sex:		Relationship:
Name:	Age:	Sex:		Relationship:
Name:	Age:	Sex:		Relationship:
Name:	Age:	Sex:		Relationship:
Name:	Age:	Sex:		Relationship:

Availability for ABA Therapy

Please indicate your availability for therapy by marking which times you would be available.

Monday	☐ 9am – 11am	☐ 11am – 1pm	☐ 1pm – 3pm	☐ 3pm – 5pm
Tuesday	☐ 9am – 11am	☐ 11am – 1pm	☐ 1pm – 3pm	☐ 3pm – 5pm
Wednesday	☐ 9am – 11am	☐ 11am – 1pm	☐ 1pm – 3pm	☐ 3pm – 5pm
Thursday	☐ 9am – 11am	☐ 11am – 1pm	☐ 1pm – 3pm	☐ 3pm – 5pm
Friday	☐ 9am – 11am	☐ 11am – 1pm	☐ 1pm – 3pm	☐ 3pm – 5pm
Saturday	☐ 9am – 11am	☐ 11am – 1pm	☐ 1pm – 3pm	☐ 3pm – 5pm
Sunday	☐ 9am – 11am	☐ 11am – 1pm	☐ 1pm – 3pm	☐ 3pm – 5pm

☐ I only have availability after 5pm. *(If this box is checked, we will contact you to see if we will be able to work out a schedule. Please note that services are not typically rendered after 5pm.)*

Primary Insurance or Funding Source

☐ Insurance ☐ Autism Scholarship ☐ Jon Peterson Scholarship ☐ DODD/POLR ☐ Private Pay ☐ Other:

Name of Funding Source:		Phone #:
Member ID:	Group #	
Policy Holder Information:		
Name:	DOB:	SSN:
Relationship to Client:		
Additional Information:		

Secondary Insurance or Funding Source

☐ Insurance ☐ Autism Scholarship ☐ Jon Peterson Scholarship ☐ DODD/POLR ☐ Private Pay ☐ Other:

Name of Funding Source:		Phone #:
Member ID:	Group #	
Policy Holder Information:		
Name:	DOB:	SSN:
Relationship to Client:		
Additional Information:		

Treatment History

Has the client/child received other therapies in the past as an effort to treat their primary diagnosis (aside from PT, OT, and Speech)?
☐ yes ☐ no

If yes, please list all previous providers and information about each below:

Provider:	Date Treatment Started:	Date Treatment Ended:
What types of therapeutic interventions were used? ☐ ABA Therapy ☐ Other (please explain):	What was the client/child's response to this treatment?	
Provider:	Date Treatment Started:	Date Treatment Ended:
What types of therapeutic interventions were used? ☐ ABA Therapy ☐ Other (please explain):	What was the client/child's response to this treatment?	
Provider:	Date Treatment Started:	Date Treatment Ended:
What types of therapeutic interventions were used? ☐ ABA Therapy ☐ Other (please explain):	What was the client/child's response to this treatment?	

Other Therapies

Please indicate other therapies the client/child is currently receiving. Every effort will be made to collaborate with other professionals in order to achieve the best possible outcome.

☐ Speech Date Started:	Name of Therapist (or company):	Phone Number:
	Best Contact Person:	Can CCBT Contact for Collaboration Purposes? ☐ Yes ☐ No
☐ OT Date Started:	Name of Therapist (or company):	Phone Number:
	Best Contact Person:	Can CCBT Contact for Collaboration Purposes? ☐ Yes ☐ No
☐ PT Date Started:	Name of Therapist (or company):	Phone Number:
	Best Contact Person:	Can CCBT Contact for Collaboration Purposes? ☐ Yes ☐ No
☐ Other Date Started:	Name of Therapist (or company):	Phone Number:
	Best Contact Person:	Can CCBT Contact for Collaboration Purposes? ☐ Yes ☐ No

Developmental, Medical, Behavioral, and Social History

Primary Physician:	Phone #:

Pregnancy

Complications: ☐ Vomiting ☐ Staining or blood loss ☐ Infections ☐ Toxemia ☐ Other:
Smoking During Pregnancy: ☐ Yes ☐ No Drug or Alcohol Use: ☐ Yes ☐ No
Duration of Pregnancy (weeks):_____

Delivery

Type of Labor: ☐ Spontaneous ☐ Induced Type of Delivery: ☐ Normal ☐ Breech ☐ Cesarean
Duration of Labor (hours):_____
Complications: ☐ Cord around neck ☐ Hemorrhage ☐ Infant Injury ☐ Other:

Post Delivery

☐ Jaundice ☐ Cyanosis (blue baby) ☐ Incubator Care ☐ Infection ☐ Other:

Infancy

☐ Difficult to calm or comfort ☐ Colicky ☐ Excessively irritable ☐ Head banging ☐ Difficulty Nursing
☐ Disturbed Sleep Patterns (describe):
☐ Other:

Developmental Milestones

If you can recall, record the age at which your child reached the following developmental milestones. If you do not recall the age, check the appropriate category to the best of your recollection (early, normal, late)

	Age	Early	Normal	Late		Age	Early	Normal	Late
Sat without support	_____	☐	☐	☐	Crawled	_____	☐	☐	☐
Walked w/o assistance	_____	☐	☐	☐	Said first word	_____	☐	☐	☐
Spoke in sentences	_____	☐	☐	☐	Toilet trained	_____	☐	☐	☐

Behavior/Social Checklist Please check all of the following that apply to your child:

☐ Is moody	☐ Has a bad temper	☐ Cries more easily than peers
☐ Has excessive worry	☐ Has bad dreams	☐ Is often sad
☐ Is often quieter than peers	☐ Is fearful of new situations	☐ Is fearful of being alone
☐ Is often more tired than peers	☐ Stutters or stammers	☐ Frequent stomach aches
☐ Frequent headaches	☐ Wets bed or pants often	☐ Has frequent bowel accidents
☐ Frequent diarrhea	☐ Frequent constipation	☐ Overeats
☐ Bites nails	☐ Is slow to trust	☐ Demands to be center of attention
☐ Fights with siblings (beyond normal)	☐ Excessively neat or orderly	☐ Over Concerned with germs/cleanliness
☐ Tells lies	☐ Steals	☐ Plays with fire
☐ Bullies other children	☐ Is rude or disrespectful to adults	☐ Is mean
☐ Destroys own property	☐ Destroys others property	☐ Deliberately provokes adults
☐ Frequently in trouble with neighbors	☐ Is cruel to animals	☐ Is a loner
☐ Has no real friends	☐ Has mostly younger friends	☐ Has mostly older friends
☐ Is bossed by other children	☐ Prefers to play alone	☐ Gets picked on
☐ Is not liked by other children	☐ Difficulty sustaining attention	☐ Makes careless mistakes
☐ Often does not seem to listen	☐ Fails to finish things	☐ Difficulty organizing activities
☐ Avoids sustained mental effort	☐ Often loses things	☐ Easily distracted
☐ Forgetful in daily activities	☐ Often fidgets	☐ Often can't stay in his/her seat
☐ Is hyperactive	☐ Difficulty playing quietly	☐ Talks excessively
☐ Difficulty waiting turn	☐ Often interrupts or intrudes	☐ Talks over people

Other:

IF YOUR CHILD IS **12 YEARS OR OLDER**: Please check all the following that apply to your child.

☐ Is sexually active	☐ Expresses troubling ideas about sex	☐ Has many health complaints
☐ Behavior is rigid and repetitive	☐ Is troubled by obsessive thoughts	☐ Has times of extreme fear or panic
☐ Uses (or has used) alcohol	☐ Uses (or has used) illegal drugs	☐ Inhales household chemicals
☐ Abuses (or has abused) OTC drugs	☐ Abuses (or has abused) prescription drugs	

Known **Medical Conditions** (Past and Current):

Condition	Past	Current	*Condition*	Past	Current	*Condition*	Past	Current
Asthma	☐	☐	Liver Disease	☐	☐	Irregular Heartbeat	☐	☐
Epilepsy/Seizures	☐	☐	HIV/AIDS	☐	☐	Thyroid Issues	☐	☐
Heart Disease/Attack	☐	☐	Arthritis	☐	☐	Blood Clots	☐	☐
Stroke	☐	☐	Cancer	☐	☐	Neuropathy	☐	☐
Diabetes	☐	☐	Sleep Apnea	☐	☐	Eating Disorder	☐	☐
Depression	☐	☐	Anxiety	☐	☐	Other:	☐	☐
Psychiatric Illness	☐	☐	Anemia	☐	☐	Other:	☐	☐
Head Injury	☐	☐	Positive TB Test	☐	☐	Other:	☐	☐

For all conditions marked above (either past or current), please list:

For which condition:	Provider who is (or was) overseeing this condition:	Dates of Treatment	How is (or was) this condition being treated:	Did the client/child respond favorably to treatment:
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Current Medications:

Medication Name	**Reason for Taking**	**Been Taking for How Long?**

Does the client/child have any **food or drug allergies?** ☐ Yes ☐ No

If you checked yes, please list all allergies and adverse reactions below:

Allergen (food or drug):	Adverse reaction to the allergen:

Does the client/child have any **dietary restrictions** aside from food allergies? ☐ Yes ☐ No

If you checked yes, please list dietary restrictions below:

Is the client/child expressing **suicidal or homicidal ideation** or have a history of harming himself/herself or others?

☐ Yes ☐ No

If you checked yes, please explain more specifically below, including dates and details of any incidents:

Has the client/child ever been the victim of abuse?

☐ No ☐ Physical ☐ Emotional/Mental ☐ Sexual

Has the client/child ever been the perpetrator of abuse?

☐ No ☐ Physical ☐ Emotional/Mental ☐ Sexual

If you checked any box other than "no" for the two questions above, has this abuse been reported to the appropriate authorities? ☐ *Yes* ☐ *No*

*(**CCBT Team Members are mandated reporters)*

Family History

Please check any conditions that are present in the client/child's family history (parents, grandparents, siblings)

☐ Heart Disease	☐ Arthritis	☐ Psychiatric Illness	☐ Cancer
☐ Heart Attack	☐ Epilepsy/Seizure Disorder	☐ Thyroid	☐ Autism
☐ Irregular Heartbeat	☐ Stroke	☐ Diabetes	☐ Other:
☐ Sudden Death	☐ Depression	☐ Bleeding/Clots	☐ Other:

Please indicate the relationship to the client/child for each condition marked above:

Parent/Guardian Concerns and Goals for ABA Therapy

In the boxes below, please describe your greatest concerns and goals for your child/client in each applicable category.

Category	Greatest Concerns	Goals
Communication		
Self-Help		
Motor Skills (fine and gross)		

Category	Greatest Concerns	Goals
Safety		
Routines		
Sleeping/Feeding		
School/Academics		
Social Skills		
Behavioral & Emotional		

Workplace Safety (Home Based ABA)

Has anyone living in the home (or any person who will visit the home during ABA sessions) ever been **convicted of a crime (misdemeanor or felony), involving violence, assault, theft, or any crime sexually related**? ☐ Yes ☐ No

Is anyone living in the home (or any person who will visit the home during ABA sessions) **a registered sex offender**? ☐ Yes ☐ No

Does anyone living in the home (or any person who will visit the home during ABA sessions) regularly abuse **alcohol**? ☐ Yes ☐ No

Workplace Safety (Home Based ABA) (cont.)

Does anyone living in the home (or any person who will visit the home during ABA sessions) regularly or occasionally abuse **illegal drugs**? ☐ Yes ☐ No

**If the answer to any of the Workplace Safety questions were "Yes", please explain:

***These questions are not asked because we intend to pry or judge any current or former situations. Because staff members work in your home, your home is a workplace. As such, we must ask these questions so that we can assess possible safety concerns in their workplace. We subject each of our staff members to yearly background checks for the same reason - so that we can, to the extent possible, make sure that having our staff in your home does not pose a foreseeable added risk to your family. Please understand that we have the right to refuse home-based services if we perceive that the safety concern is too great. If that is the case, we will offer community or center based services if at all possible.*

Other Questions

Are there any **cultural or spiritual considerations** that CCBT team members should take into account while conducting sessions with your child that could impact his or her treatment? ☐ Yes ☐ No

If yes, please explain:

Are there any **legal issues** that are relevant to the client/child receiving care with CCBT, including but not limited to custody issues? ☐ Yes ☐ No

If yes, please explain:

What **community resources**, if any, have you utilized since the client/child's diagnosis?
☐ Support groups ☐ County Board of DD ☐ Special Education Resources in your School District
☐ Other:

Do you need information or **referral** to other sources, such as other types of therapy or support groups?
☐ yes ☐ no

The information shared on this patient intake form is accurate to the best of my knowledge. If I become aware of any changes, I will notify Collaborative Care Behavioral Therapy as soon as possible.

Name of Person Completing this Form:	Relationship:
Signature:	Date: