Direction by Design LLC

Intake Form

Client Information:

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Child/Children Name: _____

Date of Birth: _____

Contact Information:

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Mother's Occupation: _____ Father's Occupation: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

School Information:

School Name: _____ Grade/placement: _____

Do they have an IEP: Yes / No Do they receive any services through school: Yes / No

Medical History:

Please note any significant family history of diagnoses and medical conditions:
Current Medications for Child/Children:

Other Services Provided (Speech/OT/PT/Social Work/Counseling):

Name of Provider	Services Provided/Times per week

Previous Experiences with ABA Therapy:

Please list any previous experiences that you may have had with ABA Therapy:

Behavior History:

Please List and describe any behavioral issues occurring now or in the past:

Please check off any skill areas that you would like to address in treatment:

	Non-compliance		Getting Dressed		Expressive Language
	Tantrums		Hygiene Skills		Attending
	Aggression		Waiting		Motivation
	Property Destruction		Accepting “No”		Task Completion
	Yelling		Sharing		Chore Completion
	Elopement		Cooperative Play		Self-monitoring Skills
	Homework Compliance		Social skills		Academic Readiness
	Morning Routine		Friendship management		Independent Transitions
	Nighttime Routine		Conflict resolution		Coping skills
	Toilet Training		Receptive Comprehension		Self-Regulation skills

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Goals for Treatment:

Please list your main overall goals for treatment:

Additional Information:

Please provide us with any additional information that may be helpful: