



"Unlocking Your Child's Journey to Independence"™

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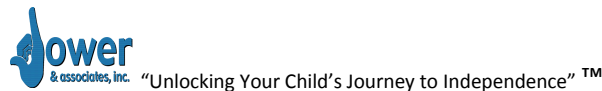
(703) 618-2272 and 702-618-6180 (business cellulars)

ABA Intake Form

Child Information		
Last Name:	Age:	
First Name:	Date of Birth:	
Middle Name:	Gender:	
Social Security Number:		
Home phone:		
Address:		
City:		
State:	Zip code:	Country:

Primary Diagnosis:	Date of Diagnosis:
Other condition:	Date of Diagnosis:
Other condition:	Date of Diagnosis:

Mother or Legal Guardian Information	
Full Name:	Relationship to Child:
Address: (if different from applicant)	Social Security Number:
City:	Occupation:
State:	Name of Employer:
Home Phone: (if different from applicant)	Business Phone:
Cell Phone:	Fax:
Pager:	Email:



* Speech/Language Evaluations and Therapy * Academic & Remedial Tutoring * Educational Consultations * IEP Development & Consultations *
* Autism Home/School Programs- Specialty: Applied Behavior Analysis (ABA) with Verbal Behavior Emphasis *

ABA Intake Form
Updated March 2008

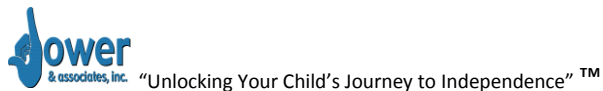
Father or Legal Guardian Information	
Full Name:	Relationship to Child:
Address: (if different from applicant)	Social Security Number:
City:	Occupation:
State:	Name of Employer:
Home Phone: (if different from applicant)	Business Phone:
Cell Phone:	Fax:
Pager:	E-mail:

Applicant's Siblings:		
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

Present School/Placement	
Name of School:	Years attended:
Address:	Placement:
Phone:	

Medical Information			
Is your child on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list medication, administration times, usage:			
Type of Medication	Dosage	Administration Times	Used for

Additional medications can be attached on a separate sheet of paper and stapled to this intake.

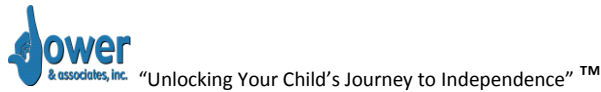


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Has the child ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations? Yes No If yes, please explain.

Please summarize the hospital/treatment facilities observation, treatment(s), and effectiveness of treatment(s).

Are there any medical conditions that need to be considered when delivering ABA treatment?
 Yes No If yes, please explain.



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Supportive Services

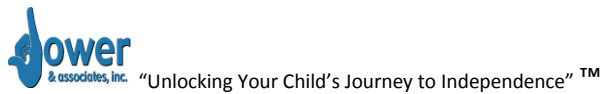
What other services is your child currently receiving both in-school and out of school? Please enclose a copy of the child's most recent IEP or IFSP and therapy goals from each area that is checked.

Service/Therapy	Location	Minutes/Week
<input type="checkbox"/> Early Intervention Services	<input type="checkbox"/> School <input type="checkbox"/> Home	
<input type="checkbox"/> Speech and/or language therapy	<input type="checkbox"/> School <input type="checkbox"/> Home	
<input type="checkbox"/> Occupational and/or Physical Therapy	<input type="checkbox"/> School <input type="checkbox"/> Home	
<input type="checkbox"/> Vision services in school	<input type="checkbox"/> School <input type="checkbox"/> Home	
<input type="checkbox"/> Hearing services	<input type="checkbox"/> School <input type="checkbox"/> Home	
<input type="checkbox"/> Other	<input type="checkbox"/> School <input type="checkbox"/> Home	
<input type="checkbox"/> Other	<input type="checkbox"/> School <input type="checkbox"/> Home	

Please describe the results of these therapies in regards to success in achieving goals.

What, if any, behavior issues does your child have? Ex., self-injurious, aggressive towards others, etc., please explain. Include methods used to decrease these behaviors.

What are your immediate goals for your child?



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What level of commitment are you willing to make at home in order for your child to achieve these goals?

What would you like us to know about your child?

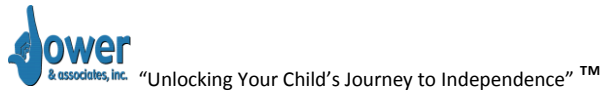
What current communication skills does your child have? Ex., sign language, PECS, verbal, please explain

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

Parent/Guardian (print name) _____

Signature of PARENT/GUARDIAN: _____

Date: _____

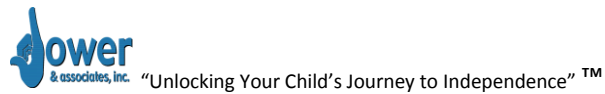


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***Please send completed form to:
Dower and Associates, Inc.
24538 Lenah Road
Aldie, VA 20105**

Include:

- Copy of most recent IEP/IFSP
- Confidentiality Release Form
- Copy of most recent comprehensive evaluation
- Copy of most recent speech/occupational therapist evaluations and goals
- Videotape (25-30 min) of your child during structured teaching
- Please include a copy of your child's completed ABLLS™-R profile or VB-MAPP, or email it separately to SLPBCBA@aol.com



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