SPECIAL LEARNING 1-ON-1 LLC
EVERY PERSON DESERVES AN OPPORTUNITY FOR INDEPENDENCE

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Intake Form

Information	Today's Date:
Last Name:	Age: yrs mths
First Name:	Date of Birth:
Middle Name:	Gender:
Cell phone:	
Address:	
City:	
State: Zip code: County: Country:	

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

Source of Funding	☐ Intervention Agency ☐ Private Pay ☐ Other:

Guardian Information if applicable	
Full Name:	Person Filling:
Address: (if different from applicant)	
City:	Occupation:
State:	Name of Employer:
Home Phone: (if different from applicant)	Business Phone:
Cell Phone:	
Email:	

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

School/s attended	
Name of School:	Years attended:
Address:	Placement:
Phone:	Degree achieved:

Medical Information

Are you on medication? ☐ No ☐ Yes
Do you have any Allergies? ? ☐ No ☐ Yes if so what?

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 application

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

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

History of Treatment of behavioral need.

❒ **Previous Treatment Provider**	Dates of service: to
Provider Agency:	
Provider Name:	
Provider Phone:	
Frequency of provider consultation:	
Methods of treatment by the provider. ☐ Counseling ☐ ABA ☐ CBT	☐ Program Other Other

Please describe services by the provider and program information.

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

Supportive Services

What other services are you <u>currently</u> receiving? Please enclose a copy of the most recent IEP or IFSP if applicable and Therapy goals from any area that is checked, if you have access to the goals.

Service/Therapy	Location	Hours/week
☐ Counseling	☐ Community ☐ Home	
☐ Speech and/or language therapy	☐ Community ☐ Home	
☐ Occupational and/or Physical Therapy	☐ Community ☐ Home	
☐ Vision services	☐ Community ☐ Home	
☐ Hearing services	☐ Community ☐ Home	
☐ Other	☐ Community ☐ Home	
☐ Other	☐ Community ☐ Home	

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

What, if any, behavior issues do you have?

What are your immediate goals in behavioral therapy*?*

What seems to be the purpose (outcome) or function of the behavior(s)? What do you achieve by using this behavior? Select possible outcomes from below. Please star predominant outcomes.

☐ Power/Control ☐ Protection ☐ Attention Seeking

☐ Acceptance/Affirmation ☐ Expression of self ☐ Gratification

☐ Justice/Revenge ☐ Environmental Distractions ☐ Avoidance

Explain:

What social support do you have in your life? Who are your friends or support people you go to in a time of need.

What level of commitment are you willing to make at home to achieve your desired goals?

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

Print Name

Signature of Individual: _____ Date: _____