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

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Intake Form

Child Information	**Today's Date:**
Last Name:	**Age: yrs mths**
First Name:	**Date of Birth:**
Middle Name:	**Gender:**
Home 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:**

Mother/Partner or Legal Guardian Information	
Full Name:	**Relationship to Child:**
Address: (if different from applicant)	
City:	**Occupation:**
State:	**Name of Employer:**
Home Phone: (if different from applicant)	**Business Phone:**
Cell Phone:	
E-mail:	
Fax:	

Father/Partner or Legal Guardian Information	
Full Name:	**Relationship to Child:**
Address: (if different from applicant)	
City:	**Occupation:**
State:	**Name of Employer:**
Home Phone: (if different from applicant)	**Business Phone:**
Cell Phone:	
Fax:	
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? ☐ No ☐ Yes
Does your child 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

Has the child 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 (allergies, medical needs…) 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 ☐ TEACCH	☐ Pivotal Response Training 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 is your child <u>currently</u> 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
☐ Early Intervention Services	☐ School ☐ Home	
☐ Speech and/or language therapy	☐ School ☐ Home	
☐ Occupational or Physical therapy	☐ School ☐ Home	
☐ Vision services in school	☐ School ☐ Home	
☐ Hearing services	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	
☐ Other	☐ School ☐ 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 current methods used to decrease these behaviors.

What are your immediate goals for your child?

What seems to be the purpose (outcome) of the behavior(s)? What does the child 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 current communication skills does your child have? Ex., sign language, PECS, verbal, please explain

Since adult responses account for roughly 95% of behavior change, what level of commitment are you prepared to make at home to support your child's progress toward these goals?

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: _____