Adult Client Intake Form

This form is fillable electronically — click into any field below to type, and use the checkboxes to select options.

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HIPAA NOTICE OF CONFIDENTIALITY

The information collected on this form is protected health information under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is gathered solely to evaluate and coordinate services for you and will be shared only with staff, providers, and agencies directly involved in your care, or as otherwise permitted or required by law. This form and any attachments will be stored securely and access is limited to authorized personnel. You have the right to request a copy of this information, request corrections, and receive our Notice of Privacy Practices. By signing this application, you acknowledge that you have been informed of this confidentiality policy.

I acknowledge this notice: ☐ Yes, I acknowledge and consent

CLIENT INFORMATION

Today's Date | Date of Birth | Age (yrs) | Age (mths)

Last Name | First Name | Middle Name

Gender | Cell Phone

Street Address

City | State | Zip Code | County | Country

Adult Intake Form

DIAGNOSIS INFORMATION

Primary Diagnosis

Date of Diagnosis (Primary)

Other Condition

Date of Diagnosis

Other Condition

Date of Diagnosis

SOURCE OF FUNDING

Select one:

- ☐ Intervention Agency
- ☐ Private Pay
- ☐ Other:

GUARDIAN INFORMATION (IF APPLICABLE)

Full Name

Person Filling Out This Form

Address (if different from applicant)

City

State

Occupation

Name of Employer

Home Phone (if different)

Business Phone

Cell Phone

E-mail

APPLICANT'S SIBLINGS (IF APPLICABLE)

Name	Age	Gender

SCHOOL(S) ATTENDED

Name of School

Years Attended

Address

Placement

Phone

Degree Achieved

MEDICAL INFORMATION

Are you on medication? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

If yes, please list allergies

If on medication, list medication, administration times, and usage

Current Medications

Type of Medication	Dosage	Administration Times	Used For

Additional medications may be attached on a separate sheet and included with this application.

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

If yes, please explain

MEDICAL CONSIDERATIONS FOR BEHAVIORAL TREATMENT

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 (From)

To

Provider Agency

Provider Name

Provider Phone

Frequency of Provider Consultation

Methods of treatment by the provider:

☐ Counseling ☐ ABA ☐ CBT ☐ Program

Other

Other

Describe services by the provider and program information

Describe the results of these therapies in achieving goals

SUPPORTIVE SERVICES

What other services are you currently receiving? Please enclose a copy of your most recent IEP or IFSP if applicable, and therapy goals from any area checked, if you have access to them.

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	

Describe the results of these therapies in achieving goals

BEHAVIOR ISSUES & GOALS

What, if any, behavior issues do you have?

What are your immediate goals in behavioral therapy?

FUNCTION OF BEHAVIOR

What seems to be the purpose (outcome) or function of the behavior(s)? What do you achieve by using this behavior? Select all that apply and star the predominant outcome(s).

- ☐ Power / Control
- ☐ Protection
- ☐ Attention Seeking
- ☐ Acceptance / Affirmation
- ☐ Expression of Self
- ☐ Gratification
- ☐ Justice / Revenge
- ☐ Environmental Distractions
- ☐ Avoidance

Explain

SOCIAL SUPPORT & COMMITMENT

What social support do you have in your life? (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?

ACKNOWLEDGMENT & SIGNATURE

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

Print Name

Signature of Individual

Date

CONSENT TO EMAIL COMMUNICATION

From time to time, Special Learning 1-ON-1 LLC may use email to communicate scheduling, general updates, or documents related to your care. Standard email is not a fully secure or encrypted method of communication, and there is some risk that messages could be intercepted or accessed by an unauthorized party. Please indicate whether you consent to this method of communication.

- ☐ I consent to email communication regarding my care
- ☐ I do not consent to email communication

Signature

Date