New Client Intake Application

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

Shawna Heiser MS BCBA Board Certified Behavior Analyst
1122 East Main Suite 4, Bozeman, MT 59715
Phone: 406-580-2640 • E-mail: speciallearning1on1@gmail.com • www.speciallearning1on1.com

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 your child and will be shared only with staff, providers, and agencies directly involved in your child's 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

CHILD INFORMATION

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

Last Name | First Name | Middle Name

Gender | Home Phone

Street Address

City | State | Zip Code | County | Country

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:

MOTHER / PARTNER OR LEGAL GUARDIAN

Full Name

Relationship to Child

Address (if different from applicant)

City

State

Occupation

Name of Employer

Home Phone (if different)

Business Phone

Cell Phone

Fax

E-mail

Pager

FATHER / PARTNER OR LEGAL GUARDIAN

Full Name

Relationship to Child

Address (if different from applicant)

City

State

Occupation

Name of Employer

Home Phone (if different)

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? ☐ Yes ☐ No

Does your child 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.

Has the child 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 (allergies, medical needs, etc.) that need to be considered when delivering behavioral treatment?

☐ Yes ☐ No

If yes, please explain

HISTORY OF BEHAVIORAL TREATMENT

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 ☐ TEACCH ☐ Pivotal Response Training

Other

Other

Describe services by the provider and program information

Describe the results of these therapies in achieving goals

SUPPORTIVE SERVICES

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

Service / Therapy	Location	Minutes / Week
☐ Early Intervention Services	☐ School ☐ Home	
☐ Speech and/or Language Therapy	☐ School ☐ Home	
☐ Occupational and/or Physical Therapy	☐ School ☐ Home	
☐ Vision Services in School	☐ School ☐ Home	
☐ Hearing Services	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	

Describe the results of these therapies in achieving goals

BEHAVIOR

What, if any, behavior issues does your child have (e.g., self-injurious, aggressive toward others)? Include current methods used to decrease these behaviors.

GOALS & FUNCTION OF BEHAVIOR

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 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

What current communication skills does your child have? (e.g., sign language, PECS, verbal)

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?

ACKNOWLEDGMENT & SIGNATURE

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

Parent / Guardian (print name)

Signature of Parent / Guardian

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 child's 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 child's care
- ☐ I do not consent to email communication

Signature of Parent / Guardian

Date