INTAKE QUESTIONNAIRE

Please complete the following intake questionnaire. Also, feel free to add any additional information or attach reports that you think may be helpful in allowing us to get to know your child. This information is helpful when developing an initial understanding of your child's needs and provides critical information for us to discuss with your insurance company to get authorization for services.

GENERAL INFORMATON

Name of Person Completing this Form: ______________________________

Relationship to Child: ______________________________

Child's Name: ______________________________

Date of Birth: ____________________ Age: ____________________

PARNT/GUARDIAN CONTACT INFORMATION

Parent/Guardian #1: ______________________________

Cell Phone: ______________________________

Email: ______________________________

Occupation: ______________________________

Parent/Guardian #2: ______________________________

Cell Phone: ______________________________

Email: ______________________________

Occupation: ______________________________

Home Address: ______________________________

Home Phone (If Applicable): ______________________________

Languages Spoken in the Home: ______________________________

MEDICAL INFORMATION

Primary Physician: ______________________________

Practice Name: ______________________________

Phone Number: ______________________________

Does your child currently have a diagnosis? ☐ Yes ☐ No
*If yes, please provide the following information:

Diagnosis	Diagnosing Physician	Date of Diagnosis

PREVIOUS & CURRENT PRIVATE SERVICES

Does your child currently or have they ever received ABA services? ☐ Yes ☐ No
*If yes, please provide the following information:

Service Provider	Duration (e.g., 30 minutes)	Frequency (e.g., 5x/week)	Dates

Does your child currently or have they ever received related services in a private setting? ☐ Yes ☐ No
*If yes, please provide the following information:

Service (e.g., Speech, OT, etc.)	Duration (e.g., 30 minutes)	Frequency (e.g., 5x/week)	Dates

INSURANCE

Primary Insurance: ____

Policy Holder: ________________________ Date of Birth: ________________________

Social Security #: ______________________ Relationship to Child: __________________

Policy #: _______________ Group #: ____________________ ID #: _______________

Address: _____________________________________ Phone: _______________

Secondary Insurance: ____

Policy Holder: ________________________ Date of Birth: ________________________

Social Security #: ______________________ Relationship to Child: __________________

Policy #: _______________ Group #: ____________________ ID #: _______________

Address: _____________________________________ Phone: _______________

DOCUMENTS

Required:

- Front & Back of Insurance Holder's Driver's License
- Front & Back of Insurance Card(s)

If Applicable:

- Diagnosing Physician Report
- Related Service Reports (e.g., speech, OT, etc.)
- Individualized Education Plan (IEP)
- Behavior Plan
- 504 Plan
- Medicaid FFS
  - FA-11F Form - Completed by Diagnosing Physician
  - FA-29A Form – Signed by Parent/Guardian When Switching Clinics