Creating Brighter Futures

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(P) 734-926-0740
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Client Intake Form

Basic Client Information

Client Name: Nickname: ☐

Date of Birth: Age: Gender: Male ☐ Female

Address:

City/State: Zip Code: County:

Please indicate which service(s) you are interested in at CBF:

☐ ABA Therapy ☐ Social Skills

Parent/Guardian Information (if applicable)

Parent/Guardian Name: Occupation:

Phone Number: Email:

Address:

City/State: Zip Code: County:

Parent/Guardian Name: Occupation:

Phone Number: Email:

Address:

City/State: Zip Code: County:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Others Living in the Home:

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

Responsible Party Information

Please fill out the following information regarding the person who is financially responsible for the client attending Creating Brighter Futures

Guarantor's Name: DOB:
Social Security Number: Relation to Client:
Address:
Phone Number:
Employer:

To which email address should we send your invoices?_____

_____ _____
Signature of the Individual assuming Financial Responsibility Date

Insurance Information

Either attach a photocopy of both sides of **all** applicable insurance cards or email a photo to mkubek@creatingbrighterfutures.com **prior** to the start of initiating services at Creating Brighter Futures.

Primary Insurance:
Subscriber's Name: DOB:
Policy ID #: Group #:
Relation to Client:

Secondary Insurance:
Subscriber's Name: DOB:
Policy ID #: Group #:
Relation to Client:

Medicaid Insurance:
Consumer Number: County:
Case Manager Name: Case Manager Number:

Insurance Coverage Information

As the insurance plan holder, or subscriber, you are responsible for knowing your benefits. In order to obtain the most accurate overview of your plan's benefits and your individual cost for services, you must call the 1-800 "member" number on the back of your insurance card and talk to a customer service representative.

By dialing the number on the back of your insurance card and giving the representative the name, date of birth, and insurance ID number for the child coming to Creating Brighter Futures, **please complete the following**:

Do they have Autism, or ABA, benefits?_____

What are the Autism, or ABA, benefits?_____

_____

Is Creating Brighter Futures an in-network provider?_____

(Our NPI, or National Provider Identification number is 1881939346)

What is our deductible?_____

What is our copay?_____

If needed, the diagnosis code for Autism is F84.0

If needed, the specific ABA CPT, or service codes, that would be used are:

97151_____

97153_____

97154_____

97155_____

97156_____

97157_____

Is there a limit on the number of visits for Autism, or ABA, services?_____

Is there a maximum amount limit on the benefits for the year?_____

Diagnostic Information - **Please provide a copy of all diagnostic evaluations**

Diagnosis:

Date of Diagnosis:

Who provided this diagnosis?

Diagnosis:

Date of Diagnosis:

Who provided this diagnosis?

Diagnosis:

Date of Diagnosis:

Who provided this diagnosis?

Is there a family history of developmental and/or speech delay? ☐ Yes ☐ No

If yes, please explain:

Medical History

Primary Physician Name: Phone Number:

Practice Name/ Location: Fax Number:

Any pertinent medical conditions, hospitalizations or surgeries?

Please list all current medications and dosages:

Medication	Purpose	Dosage	Date Started

Please list any allergies your child has:

Allergies	Reaction	Treatment Protocol

Behavior History

Please list any challenging behaviors your child currently engages in:

Behavior	How often does it occur?	Is there anything that you know will trigger the behavior?	Is there anything you know that will make your child stop engaging in the behavior?

Please list any self-stimulatory behaviors your child currently engages in:

Behavior	How often does it occur?	Is there anything that you know will trigger the behavior?	Is there anything you know that will make your child stop engaging in the behavior?

Communication

When/Where was their most recent hearing test? _____Vision test?_____

Please list the results and any concerns_____

Does your child currently have any swallowing difficulties or eating concerns? ☐ Yes ☐ No

If yes, please explain _____

Which of the following areas of communication do you feel your child may need Speech Therapy to improve?

☐ Understanding language ☐ Expressing Language ☐ Speech Sounds

☐ Fluency/Stuttering ☐ Voice ☐ Social Communication

When did you first become concerned?_____

In regards to social skills and play, does your child:

Make eye contact with others? ☐ Yes ☐ No

Imitate others? ☐ Yes ☐ No

Use toys with their intended purpose? ☐ Yes ☐ No

Seek out interaction with: ☐ Adults ☐ Peers ☐ Siblings

Does your child currently: (check all that apply)

☐ Follow simple (check all that apply): ☐ 1 step direction ☐ 2 step directions ☐ 3+ step directions

☐ Point to/ go to/ reach for/ or otherwise identify people and objects that you name?

☐ Point to basic body parts that you name?

☐ Answer simple yes/no questions accurately?

☐ Answer simple what, where, who, when, why, how questions accurately?

☐ Understand prepositions (such as: in, under, on)?

☐ Understand color and size words?

Which of the following describes how your child communicates: (check all that apply)

☐ Pointing, gesturing, vocalizing

☐ Eye contact, facial expressions

☐ Babbling

☐ Pulls person to desired object

☐ Gives items/tangible symbols to communicate

☐ Pictures

☐ Communication boards/books

☐ Frequency_____

☐ Sign Language

☐ Single words (about how many?)_____

☐ Two-word phrases

☐ Three or four word utterances

☐ Full sentences with some errors

☐ Grammatically correct sentences

☐ Writing

☐ Communication device (kind?)_____

☐ Frequency_____

☐ Other_____

Communication Continued

Does your child communicate (verbally or non-verbally) to: (check all that apply)

☐ Ask for wants/needs? ☐ Ask questions? ☐ Get your attention?
☐ Greet people? ☐ Ask for help? ☐ Share information?
☐ Label people, things, or pictures around them?

If your child speaks:

Do you have difficulty understanding their speech? ☐ Yes ☐ No ☐ Sometimes
How much of what they say do you understand? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%
Do others have difficulty understanding their speech? ☐ Yes ☐ No ☐ Sometimes
How much of what they say do others understand? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

How does your child react when they are not understood? (repeats, modifies message, gives up, et

_____
_____
_____
_____

Do they repeat words or parts or words when trying to speak? ☐ Yes ☐ No ☐ Example:

_____

Do they "get stuck" and are not able to get a word out? ☐ Yes ☐ No ☐ Example:

_____

Does their rate of speech seem to be too fast or too slow? ☐ Fast ☐ Slow ☐ Normal
Does their voice sound hoarse or cut in and out when they speak? ☐ Yes ☐ No
Do they speak at a volume that causes them to stand out socially? ☐ Yes ☐ No
Do they speak in a pitch abnormally high or low for their age/gender? ☐ Yes ☐ No

Caregiver Input

Please indicate the most liked and disliked items in each category below:

	Likes	Dislikes
Food		
Toys/Objects		
Activities @ Home		
Activities/Outings in the Community		
Other		

Caregiver Input Continued

What are your child's strengths?

What are your child's areas in need of improvement?

Does your child participate in any extracurricular activities? If so, please list them:

Goals

Please list your top three immediate/short term goals:

1.	
2.	
3.	

Please list your top three long term goals:

1.	
2.	
3.	

Education & Therapy History

Please indicate all past/current educational and therapy providers. Attach any recent evaluations.

Education Provider

Name of School:
Classroom Type:
Teacher's Name: Grade:
Address:
Phone Number:
Current Schedule:
Does your child have a 504/IEP? ☐ Yes ☐ No

Behavior Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Speech Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Occupational Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Other Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Counseling Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Printed Name of Person Completing Forms _____

Signature of Person Completing Forms _____

Date Completed _____