Behaviors observed:

Behavior	How often does it happen in a day/week?	What does it look like?
Aggression (hurting other people)		
Elopement (running away from an adult, leaving the building, running off in public		
Crying/screaming		
Self-injurious behavior (hurting themselves)		
Tantrum		

Medications:

Name of medication	Dosage	Reason for medication

Other Services:

Service	Have they used this	What company	What time
Physical Therapy	Past ____ Current _____		
Speech Therapy	Past ____ Current _____		
Occupational Therapy	Past ____ Current _____		
Feeding Therapy	Past ____ Current _____		
Talk Therapy	Past ____ Current _____		
Other	Past ____ Current _____		

Diagnosis:

Diagnosis	Who made the diagnosis	When

Allergies:

Allergen	What happens if they are exposed?

Early Development:

Any difficulties in the pregnancy? _____

_____

_____

How many weeks gestation at delivery? _____

Any problems during or after birth? _____

_____

_____

Did he/she meet early milestones such as sitting, rolling, crawling, walking, babbling, speaking?

_____

_____

What made you seek a diagnosis? _____

_____

How does he/she sleep? (how many hours/night, do they struggle to fall asleep/stay asleep, if they wake how long before they fall asleep again?) _____

_____

_____

Does he/she eat a regular diet? _____

_____

What are you most concerned about? _____

_____

_____

What is your main goal for ABA therapy? _____

_____

_____

____ I understand that ABA therapy is intensive. It requires a minimum of 15 hours per/ week. My child may benefit from even more hours, this will be discussed with be if that is the case.

____ I understand that I am responsible for having my child in therapy every day. They will not make progress without a consistent schedule. I will have an adult over the age of 18 available to stay with my child for all in-home sessions. I will provide transportation to and from center sessions.

____ I understand that ABA therapy requires parent participation. I will make myself available at least once a month for a one-hour meeting with my BCBA. I will notify my team of any changes at home including medications, living arrangements, diet changes, behavior changes, or anything else that could affect how my child behaves or is able to participate in therapy.

____ I understand that I have the right to refuse services. I will have the opportunity to review all treatment plans, behavior plans, and programs. I have to right to say no to anything that makes me uncomfortable. If I give consent, I have the right to withdraw it at any time.

____ I understand that RBTs and BCBAs working with my child are professionals there to help my child. I will maintain a professional relationship with them. I will not call them to talk about personal matters that do not relate to my child, add them on social media, or make plans with them outside of therapy.

Schedule: list times you are available. We require a minimum of 15 hours/week with 3-hour sessions. Please chose mornings or afternoons, if either will work simply write “open.”

Morning (8-12)

Monday	Tuesday	Wednesday	Thursday	Friday

Afternoon (1-5)

Monday	Tuesday	Wednesday	Thursday	Friday

I agree that my child will be available for services at the times listed above. If I need to change my schedule it may affect my child’s ability to maintain services.

_____ _____

Guardian signature date