ABA Client Registration & Intake Form

702-501-9217 • hello@mysunshinetherapies.com • www.mysunshinetherapies.com

Thank you for choosing Sunshine Therapies. Please complete all sections as fully as possible.

1 CLIENT INFORMATION

Child's Full Name:

Date of Birth: Age: Gender:

Primary Language: Home Address:

City: State: Zip Code:

2 PARENT / GUARDIAN INFORMATION

Parent / Guardian 1

Name: Relationship to Child:

Phone Number: Email Address:

Parent / Guardian 2

Name: Relationship to Child:

Phone Number: Email Address:

Preferred Method of Contact

☐ Phone ☐ Text ☐ Email

3 INSURANCE INFORMATION

Primary Insurance

Primary Insurance Company:

Member ID: Group Number:

Policy Holder Name: Policy Holder DOB:

Secondary Insurance (if applicable)

Insurance Company: Member ID:

Medicaid Information (if applicable)

Medicaid ID Number:

4 REFERRAL INFORMATION

How did you hear about Sunshine Therapies?

☐ Physician ☐ School ☐ Friend / Family ☐ Insurance Company

☐ Internet Search ☐ Social Media ☐ Community Event ☐ Other

Why are you seeking ABA services at this time?

☐ New diagnosis ☐ Recommended by physician ☐ Recommended by school

☐ Transitioning from another ABA provider ☐ Challenging behaviors have increased ☐ Communication concerns

☐ Social skill concerns ☐ Daily living skill concerns ☐ Other

5 DIAGNOSIS INFORMATION

Does your child have any of the following diagnoses?

☐ Autism Spectrum Disorder (ASD) ☐ ADHD ☐ Intellectual Disability

☐ Anxiety Disorder ☐ Speech / Language Disorder ☐ Genetic Disorder

☐ Other

ABA Client Registration & Intake Form

702-501-9217 • hello@mysunshinetherapies.com • www.mysunshinetherapies.com

Date of Diagnosis: _____ Diagnosing Provider: _____

6 DEVELOPMENTAL HISTORY

Pregnancy History

Were there any complications during pregnancy?

☐ No ☐ Yes

If yes, please explain:

_____

Was the pregnancy considered high-risk?

☐ No ☐ Yes

Did any of the following occur during pregnancy?

☐ Gestational diabetes ☐ High blood pressure ☐ Maternal illness

☐ Infection ☐ Hospitalization ☐ Significant stress or trauma

☐ Other

Birth & Delivery History

Was your child:

☐ Full-term ☐ Premature ☐ Post-term

Birth Weight: _____ Delivery Type (Vaginal / C-Section): _____

Were there any complications during labor or delivery?

☐ No ☐ Yes

If yes, please explain:

_____

Did your child require:

☐ NICU stay ☐ Oxygen support ☐ Feeding tube

☐ Extended hospitalization ☐ None

NICU Length of Stay: _____

Developmental Milestones

Age sat independently: _____ Age crawled: _____ Age walked: _____

Age first words: _____ Age speaking in phrases: _____ Age toilet trained: _____

Have you ever had concerns regarding:

☐ Speech Development ☐ Social Development ☐ Motor Skills

☐ Learning Ability ☐ Sensory Processing ☐ None

7 MEDICAL HISTORY

Has your child ever had surgery?

☐ No ☐ Yes

If yes, please describe:

_____

Does your child currently have, or have a history of:

- [ ] Seizures
- [ ] Epilepsy
- [ ] Asthma
- [ ] Sleep Disorder
- [ ] Feeding Disorder
- [ ] Gastrointestinal Issues
- [ ] Chronic Constipation
- [ ] Hearing Impairment
- [ ] Vision Impairment
- [ ] ADHD
- [ ] Anxiety
- [ ] Depression
- [ ] Genetic Disorder
- [ ] Other

Current Medications

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Allergies

Does your child have any allergies?

- [ ] Food Allergies
- [ ] Medication Allergies
- [ ] Environmental Allergies
- [ ] No Known Allergies

Please specify:

_____

Dietary Restrictions

- [ ] No
- [ ] Yes

Please describe:

_____

8 EDUCATIONAL INFORMATION

School Name: _____ Current Grade: _____

Current Educational Placement:

- [ ] General Education
- [ ] General Education with Supports
- [ ] Special Education Classroom
- [ ] Autism Program
- [ ] Private School
- [ ] Homeschool

Does your child currently have:

- [ ] IEP
- [ ] 504 Plan
- [ ] Neither

Date of Most Recent IEP Meeting: _____

Does the school report behavioral concerns?

- [ ] Yes
- [ ] No

If yes, please explain:

_____

Current School-Based Services:

- [ ] Speech Therapy
- [ ] Occupational Therapy
- [ ] Physical Therapy
- [ ] Counseling
- [ ] Behavioral Support Services
- [ ] Other

9 PREVIOUS SERVICES

Is this your first time applying for ABA services?

- [ ] Yes
- [ ] No

Has your child previously received ABA services?

- [ ] Yes
- [ ] No

Previous ABA Provider: _____

Dates of Service: _____ Approx. Hours Per Week: _____

Reason Services Ended:

Has your child previously received:

- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Counseling
- ☐ Social Skills Training
- ☐ ABA Therapy
- ☐ Other

10 COMMUNICATION SKILLS

How does your child communicate?

- ☐ Full Sentences
- ☐ Short Phrases
- ☐ Single Words
- ☐ AAC Device
- ☐ PECS
- ☐ Nonverbal

Can your child independently request desired items?

- ☐ Yes
- ☐ No

Can your child answer questions?

- ☐ Yes
- ☐ No

Can your child follow one-step directions?

- ☐ Yes
- ☐ No

Can your child follow multi-step directions?

- ☐ Yes
- ☐ No

11 CHILD STRENGTHS, TALENTS & INTERESTS

What are your child's greatest strengths?

- ☐ Strong Memory
- ☐ Reading
- ☐ Math
- ☐ Art
- ☐ Music
- ☐ Technology
- ☐ Athletics
- ☐ Creativity
- ☐ Problem Solving
- ☐ Sense of Humor
- ☐ Kindness
- ☐ Leadership
- ☐ Other

What are your child's talents?

What does your child do exceptionally well?

What makes your child happiest?

12 REINFORCER & PREFERENCE INFORMATION

What items or activities does your child enjoy most?

- ☐ iPad / Tablet
- ☐ YouTube
- ☐ Video Games
- ☐ Legos
- ☐ Music
- ☐ Arts & Crafts
- ☐ Drawing
- ☐ Books
- ☐ Outdoor Play
- ☐ Sports
- ☐ Sensory Toys
- ☐ Trains
- ☐ Cars
- ☐ Animals
- ☐ Pretend Play
- ☐ Other

Favorite Toys:

Favorite Activities:

ABA Client Registration & Intake Form

702-501-9217 • hello@mysunshinetherapies.com • www.mysunshinetherapies.com

Favorite Foods: Favorite Snacks: Favorite Drinks:

What rewards work best for your child?

What rewards have NOT worked well?

13 BEHAVIOR CONCERNS

Please indicate behaviors currently occurring:

- ☐ Tantrums
- ☐ Aggression
- ☐ Self-Injury
- ☐ Property Destruction
- ☐ Elopement / Wandering
- ☐ Noncompliance
- ☐ Verbal Aggression
- ☐ Feeding Difficulties
- ☐ Sleep Difficulties
- ☐ Toileting Concerns
- ☐ Repetitive Behaviors
- ☐ Other

14 BEHAVIOR TRIGGERS & ANTECEDENTS

What commonly triggers challenging behaviors?

- ☐ Being told 'No'
- ☐ Waiting
- ☐ Transitions
- ☐ Changes in routine
- ☐ Difficult tasks
- ☐ Schoolwork
- ☐ Removal of preferred items
- ☐ End of preferred activities
- ☐ Communication difficulties
- ☐ Sensory sensitivities
- ☐ Loud noises
- ☐ Crowded environments
- ☐ Hunger
- ☐ Fatigue
- ☐ Illness
- ☐ Sibling interactions
- ☐ Community outings
- ☐ Hygiene routines
- ☐ Other

In your opinion, why do tantrums most often occur?

- ☐ To avoid a task
- ☐ To obtain a preferred item
- ☐ To gain attention
- ☐ Frustration
- ☐ Difficulty communicating
- ☐ Sensory discomfort
- ☐ Changes in routine
- ☐ Anxiety
- ☐ Emotional regulation difficulties
- ☐ Not sure
- ☐ Other

15 TANTRUM PROFILE

When your child becomes upset, which behaviors occur?

- ☐ Crying
- ☐ Screaming
- ☐ Dropping to floor
- ☐ Throwing objects
- ☐ Hitting
- ☐ Kicking
- ☐ Biting
- ☐ Scratching
- ☐ Property destruction
- ☐ Running away
- ☐ Head banging
- ☐ Self-injury
- ☐ Verbal aggression
- ☐ Other

Frequency:

- ☐ Multiple times daily
- ☐ Daily
- ☐ Several times weekly
- ☐ Weekly
- ☐ Rarely

Typical Duration:

- ☐ Less than 5 minutes
- ☐ 5-15 minutes
- ☐ 15-30 minutes
- ☐ More than 30 minutes

What are the earliest warning signs that your child is becoming upset?

What helps your child calm down?

What strategies have NOT worked?

16 SAFETY RISK ASSESSMENT

Has your child ever:

- ☐ Eloped from home
- ☐ Been lost in public
- ☐ Injured another person
- ☐ Been hospitalized for behavioral concerns
- ☐ Been suspended from school
- ☐ Eloped in the community
- ☐ Injured themselves
- ☐ Required emergency medical treatment
- ☐ Required crisis intervention
- ☐ None

Please explain any safety concerns:

17 FAMILY GOALS

What are your top concerns today?

What are your top five goals for ABA services?

What would success look like for your child and family after 6-12 months of ABA services?

18 SCHEDULING & SERVICE AVAILABILITY

Preferred Service Location:

- ☐ Home
- ☐ School
- ☐ Community

Preferred Service Times:

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

Preferred Days:

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday

Who should be contacted regarding scheduling?

ABA Client Registration & Intake Form

702-501-9217 • hello@mysunshinetherapies.com • www.mysunshinetherapies.com

Name: _____ Phone: _____

Email: _____

Are all legal guardians in agreement with ABA services?

☐ Yes ☐ No ☐ Not Applicable

19 REQUIRED DOCUMENTS

Please provide copies of the following if available:

☐ Autism Diagnostic Report
☐ Most Recent IEP
☐ Medicaid Card
☐ Previous ABA Assessment
☐ Other Relevant Medical Records
☐ Psychological Evaluation
☐ Insurance Card (Front & Back)
☐ Guardianship / Custody Documents
☐ Previous ABA Treatment Plan

PARENT / GUARDIAN CERTIFICATION

I certify that the information provided in this intake packet is accurate and complete to the best of my knowledge.

Parent / Guardian Name: _____

Signature: _____ Date: _____

Relationship to Child: _____