

INITIAL INTAKE PACKET - Stacey Ashton, MEd, BCBA.

Please have this form filled out before your first appointment.

NAME OF CLIENT _____ AGE _____ DOB _____

NAMES OF IMMEDIATE FAMILY
MEMBERS _____

MARITAL STATUS (if child, status of parents): (circle) SINGLE, MARRIED, SEPARATED,
DIVORCED

EMAIL ADDRESS: _____

ADDRESS: Street

City _____ State _____ Zip code _____

PHONE

(H) _____ (W) _____ (C) _____

NAME OF SCHOOL _____ GRADE OR
EQUIVALENT _____

WHAT KIND OF CLASS IS STUDENT IN: (For children and adolescents only. Circle all that apply:

1. REGULAR EDUCATION/FULLY MAINSTREAMED
2. REGULAR ED WITH SUPPORTS (AIDE, 504 PLAN, IEP, OTHER
_____)
3. RESOURCE ROOM FOR SUBJECTS:

4. SELF-CONTAINED CLASS
5. SPECIAL ED SCHOOL
6. DISCRETE TRIAL OR ABA HOME PROGRAM

7. OTHER:

ANY FORMAL
DIAGNOSES

_ Date of Diagnoses _____

ANY MEDICATIONS (dose and
frequency) _____

SPECIFIC CONCERNS: (State your specific concerns and those expressed by teachers and others.)

ANY AGGRESSIVE BEHAVIORS (e.g., hitting, biting, or verbal
threats) _____

POSSIBLE SERVICES DESIRED: Circle desired services

1. SOCIAL SKILLS NEEDS ASSESSMENT
2. ABA THERAPY
3. SOCIAL SKILLS: INDIVIDUAL
4. SOCIAL OPPORTUNITIES
6. FRIEND GROUP
7. PEER SENSITIVITY TRAINING
8. FUNCTIONAL BEHAVIOR ASSESSMENT

AVAILABILITY FOR APPOINTMENT TIMES (the more times you list, the easier it will be to make an appointment)

REFERRAL

SOURCE: _____
