AACT
ADVANCED AUTISM
CENTER FOR TREATMENT

Client Intake Form

Critical Information

Client's First/Last Name: _____DOB: _____

Primary Contact First/Last Name: _____

Primary Phone #: _____ Primary Email: _____

Primary Address: _____

_____

Secondary Contact First/Last Name: _____

Secondary Contact Phone # and/or Email:_____

Services Needed (circle all that apply):

Habilitation | Respite | ABA | Speech Therapy | Occupational Therapy | Psychological Eval

Primary Language(s) Spoken: _____

Primary Physician's Name: _____ Physician's Phone #: _____

Client's School: _____

School Attendance Days and Times: _____

_____

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Client's Current Services: _____

Therapy Location/Agency: _____

Any Medications? (circle one): Yes | No

If yes, please specify medications: _____

Insurance Company Name: _____

Primary Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder Employer: _____

Insurance Policy Number (required): _____

Insurance Group Number (required): _____

State Health Insurance Plan: _____

DDD/DDP Coordinator Name: _____

DDD/DDP Coordinator Email/Phone: _____

I Understand and Consent to the Following:

⬜ I provide consent for AACT to bill my insurance and I acknowledge that I will be responsible to pay should there be no coverage.

⬜ I understand AACT may share information and discuss this case with Therapists, Medical Doctors and other authorized individuals in order to treat the client.

⬜ I understand I have the right to refuse treatment at any time.

⬜ I acknowledge that AACT does not solicit clients and I have chosen AACT of my own volition.

Client/Parent Signature: _____ Date: _____

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Scheduling Information

Please fill in the time(s) services are needed for each day of the week:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Health and Medical Information

Communication Level (circle all that apply):

Complex Sentences | Simple Sentences | Nods Yes/No | Gestures

Developmental Concerns: _____

_____

Allergies to (circle all that apply): Food | Medication | Bee Stings

Other:_____

Seizures(circle one): Yes | No

If yes, please detail frequency and duration: _____

_____

Assistive Devices (circle all that apply): Vision | Hearing | Dental Appliances | Physical |

AugCom | Other

If other, please explain: _____

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Diet and Feeding Information

Food: Requires Assistance with Utensils? Yes | No

Does Food Present a Choking Hazard? Yes | No

Special Diet: Requires a Feeding Tube? Yes | No

Any Feeding Concerns?_____

Beverages: Requires Assistance with Any Cup/Glass? Yes | No

Independently Requests/Obtains a Beverage? Yes | No

Balance and Mobility Information

Balance While Standing (circle one):

Excellent (not an issue) | Moderate (may become unsteady) | Poor (very unsteady, falls)

Independent Mobility (circle all that apply):

Crawling/Scooting | Kneeling | Standing | Walking | Running | Climbing | Uses Wheelchair

Behavior Information

Behavioral Concerns (circle all that apply): Aggression | Self-injurious | Property Destruction

Elopement | Self-Stimulation | Sexualized Behavior | Other: _____

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Personal Care Information

Please check ONE box for each category below:

Dressing

- ☐ Independent
- ☐ Requires Prompting
- ☐ Requires Limited Assistance
- ☐ Requires Significant Assistance

Toileting

- ☐ Independent
- ☐ Requires Prompting
- ☐ Requires Limited Assistance
- ☐ Requires Significant Assistance

Bathing

- ☐ Independent
- ☐ Requires Prompting
- ☐ Requires Limited Assistance
- ☐ Requires Significant Assistance

Dental Care

- ☐ Independent
- ☐ Requires Prompting
- ☐ Requires Limited Assistance
- ☐ Requires Significant Assistance

Medication Administration

- ☐ Independent
- ☐ Requires Prompting
- ☐ Requires Limited Assistance
- ☐ Requires Significant Assistance

Menses

- ☐ Independent
- ☐ Requires Prompting
- ☐ Requires Limited Assistance
- ☐ Requires Significant Assistance
- ☐ Not Applicable

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Client and Home Information

What are some of the client's favorite activities?

_____

Does the client have any emergency medications (Epi-Pen, seizure meds, etc.)?

_____

Are there pets in the household? If so, what kind?

_____

Does the client have any significant behaviors that we should be aware of (aggression, elopement, putting non-food items in mouth, ect.)?

_____

Is there anything that a provider should avoid doing with the client (tickles, picking them up, Hand-Over-Hand guidance, etc.)?

_____

Is there anything the client dislikes?

_____

What are some important things to know about the client and other family members at home?

_____

Are there any cultural aspects of your family that a potential provider should be aware of?

_____

Is there anything the client should not have access to (iPad, PlayDoh, slime, etc.)?

_____

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Is there anything else we should know about the client or family?

_____

Who else might be in the home while a provider is present?

_____

Who referred you to our agency?

_____

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Client/Parent Signature :_____ Date :_____