Elite Spectrum ABA

"Providing exceptional care and assistance in helping families conquer autism"

Clinic Based Client Application ©2020

Child Information

Name: _____

Nickname: _____

Date of Birth: _____ Age: _____

Phone: _____ Gender: _____

Parent/Guardian: _____

Parent/Legal Guardian Information

Parent #1

Name: _____

Relationship to Child: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Parent #2

Name: _____

Relationship to Child: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Will anyone else pick up/drop off your child? ☐ Y ☐ N

If yes, please list their contact information below:

Name: _____

Relationship to Child: _____

Best Contact Number: _____

Emergency Contact

In the event of an emergency, please list emergency contacts that we are authorized to contact.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Insurance Information

Primary Insurance Co: _____

Policy/ID #: _____ Group #: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Relationship to Child: _____

Employer: _____

In order to submit and process claims through insurance, ESABA will need a copy of your child's diagnosis and/or ABA therapy prescription from the diagnosing physician.

Health Information

Child's Primary Diagnosis:			Date of Diagnosis:	
Secondary Diagnosis:			Date of Diagnosis:	
Other Diagnoses:				
Referring Physician:			Phone #:	
May we communicate with the PCP if needed? ☐ Y ☐ N				

1. Is your child on a special diet? If so, please explain.

2. Please list any medications your child is currently taking including administration times.

3. Does your child have any allergies? If so, please list.

4. Is your child medically fragile? Please describe.

5. Is your child independent in toileting? Please describe.

6. Is your child physically handicapped, requiring the need for any special accommodations? Please describe.

7. Any other Health Information that is important for ESABA to know?

Academic Information

School District: _____

Campus: _____

Special Education or General Education: _____

Days/Times of Attendance: _____

# of students in classroom: _____

Staff to student ratio: _____

School District

Campus and Grade:

Classroom Type:
(General Ed., Life Skills, Resource, etc.)
Staff to Student Ratio:

Academically Strong Areas

Academically Weak Areas

☐ Verbal ☐ Sign Language ☐ Picture Exchange ☐ Combination

Mode of Communication

Behavioral Information

Problem Behaviors:

☐ Aggression
☐ Throw objects
☐ Tantrums
☐ Spits
☐ Self-Injurious
☐ Property Destruction
☐ Runs from assigned areas
☐ Pica (eats nonfood items)

Other:

How do you usually handle these problem behaviors?

What are the top two behaviors you'd like to see decrease?

Reinforcers:

- ☐ Salty Foods
- ☐ Praise/Attention
- ☐ Frequent Breaks
- ☐ Peer Interactions
- ☐ Toys
- ☐ Sweet Foods

Describe the things your child has high preference for and might work for:

Reinforcement/ Preferences

Describe the items/activities your child enjoys:		
Identify typical reinforcers in these groups:		
Food:		
Toys:		
Praise:		
Physical Activity:		

General Summary

Tell us anything else about your child that you would like his/her therapist/counselors to know to better help them work together.

Goals & Expectations

Rank from 1-5 the order of your prioritized goals and skill areas for your child (eg. Language, socialization, reducing challenging behaviors, play, self-help, toileting):

1.

2.

3.

4.

5.

Please indicate your child's weekly schedule including any preferred times and/or times that will **not** work (nap times, preschool, sports practices, sibling activities, other therapy services, etc.) for weekly clinic based sessions.

This schedule will serve as a guideline, not a guarantee, for ESABA to use when finding a session time that works for best for your child.

For efficacy of treatment, ESABA requires a minimum of 4 hours per week of ABA therapy.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00					
8:30					
9:00					
9:30					
10:00					
10:30					
11:00					
11:30					
12:00					
12:30					
1:00					
1:30					
2:00					
2:30					
3:00					
3:30					
4:00					
4:30					
5:00					
5:30					
6:00					

How many total hours were you hoping to receive? _____

Upon completion, email application to info@elitespectrumaba.com. Please allow 1-2 business days for a response.