SILVEIRA
Behavior Consultants

Intake Form

ABA Services

Client Information:

Client Name: _____

Address: _____

Social Security No.: _____

Gender: M F

Date of Birth: _____

Parent/Guardian Information:

Mother's Name: _____

Address: _____

Preferred Phone: _____

Occupation: _____

Father's Name: _____

Address: _____

Preferred Phone: _____

Occupation: _____

Siblings/Household Members (Other than parent/guardian)

Name: _____

Date of Birth: _____

Relationship: _____

Name: _____

Date of Birth: _____

Relationship: _____

Name: _____

Date of Birth: _____

Relationship: _____

Name: _____

Date of Birth: _____

Relationship: _____

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

Emergency Contact Information

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship to Child: _____ Relationship to Child: _____

Other Services Provided (Speech/PT/OT, etc.):

Name of Provider: _____

Services Provided/Times per week: _____

Name of Provider: _____

Services Provided/Times per week: _____

Name of Provider: _____

Services Provided/Times per week: _____

Diagnosis:

Primary Diagnosis 1: _____

Diagnosis Date(s): _____

Diagnosing Professional: _____

Primary Diagnosis 2: _____

Diagnosis Date(s): _____

Diagnosing Professional: _____

Primary Diagnosis 3: _____

Diagnosis Date(s): _____

Diagnosing Professional: _____

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

Medical Conditions (if any): _____

Allergies: _____

Diagnosing Professional: _____

Special Diet Information: _____

Current Medications:

_____

_____

_____

Medication Dosage Frequency :

_____

_____

_____

Available Service Times:
Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

What are your goals and/or expectations for the services requested?

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

Problem Behavior Information

Behavior (Describe What it Looks Like)	Frequency (Hourly, Daily, Weekly, etc.)	Duration (Seconds, Minutes, Hours, Days)	Intensity (Low, Moderate, High)

What situations are these behaviors MOST likely to occur?
(Days/times/settings/activities/persons present)

What situations are these behaviors LEAST likely to occur?
(Days/times/settings/activities/persons present)

What typically happens right BEFORE problem behavior occurs?

What typically happens right AFTER problem behavior occurs?

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

What current treatments are being implemented?

What treatments have been implemented in the past?

What motivates/interests your child?

Please list any other important information you would like us to know about your child.

Describe your child's ability to label items, events, or actions (spontaneous? how many? how often?):

What typically happens right BEFORE problem behavior occurs?

What typically happens right AFTER problem behavior occurs?

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

What current treatments are being implemented?

What treatments have been implemented in the past?

What motivates/interests your child?

Please list any other important information you would like us to know about your child.

Describe your child's ability to label items, events, or actions (spontaneous? how many? how often?):

Describe your child's ability to answer questions:

Miladys Rodriguez Silveira, M.S., BCBA

Phone +1 (312) 414-8000

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

Receptive Language Skills

Describe your child's ability to follow directions and routines within context or with model:

Describe your child's ability to follow directions and routines out of context or without a model:

Describe your child's response when addressed by others:

Describe your child's interest in doing what others are doing:

Describe your child's ability to participate in turn-taking activities:

Is your child conversational? Y N Describe:

Does he/she get "stuck" on certain topics? Y N Describe:

Play Skills

Describe your child's play with toys (identify the toys and length of time involved):

Does your child use the toys as intended or as self-stimulatory objects?

Describe your child's interactive play with other children:

Describe your child's imaginative and pretend play skills:

Self-Help Skills

Describe how your child feeds him/herself:

Is your child toilet trained completely? Y N

If not, what program did you use or have your tried with your child?

Does your child dress independently: Y N Describe:

Describe any household tasks that your child assists with:

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

Describe how your child responds to situations of danger:

Child's Educational Background

School:_____ Grade:_____

_____ Home School

_____ Life Skills

_____ Emotional Support

_____ General Education

_____ Autism Support

_____ Learning Support

_____ Private School

_____ Speech/Language

Contact Name:_____ Phone Number:_____

Please attach the most recent copy of your child's IEP, RR, ETR, FBA and/or BIP.

SILVEIRA
Behavior Consultants

Intake Form

ABA Services

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Silveira Behavior Consultants, LLC. I understand that I am financially responsible for any balance. I also authorize Silveira Behavior Consultants, LLC or insurance company to release any information required to process my claims and to establish service eligibility/authorizations.

Client's Name: _____ DOB: _____

Parent/Guardian Printed Name

_____

Date: _____

Parent/Guardian Signature

_____