ALL KIDS FIRST

“ enhancing your child’s potential”

Intake Form

Child First Name: _____ Today’s Date: _____

Last Name: _____ Date of Birth: _____

Middle Name: _____ Age: ____ years ____ months

Home Phone: _____ Gender: _____

Address: _____

City: _____ State: ____ Zip: _____ County: _____

Race/Ethnicity: _____

Insurance: _____

Insurance Holder: _____

Mother or Legal Guardian Information

Full Name: _____ Relationship to Child: _____

Marital Status: _____ DOB: _____

Address: (if different from child) _____

City: _____ State: _____ Cell Phone: _____

Home Phone: _____ E-mail: _____

Occupation: _____ Employer: _____ Business Phone:

_____

Father or Legal Guardian Information

Full Name: _____ Relationship to Child: _____

Marital Status: _____ DOB: _____

Address: (if different from child) _____

City: _____ State: _____ Cell Phone: _____

Home Phone: _____ E-mail: _____

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Occupation: _____ Employer: _____

Business Phone: _____

Emergency Contact Full Name: _____ Phone: _____

Relationship to Child: _____ Phone: _____

Who has current custody/guardianship of child? Check all that apply.

____ both parents ____ mother ____ father ____ relative: _____ other: _____

***If there is a parenting plan, please provide a copy**.

Other People Living in the Home

Name: _____ Relationship: _____ Age: _____ Gender: _____

Name: _____ Relationship: _____ Age: _____ Gender: _____

Name: _____ Relationship: _____ Age: _____ Gender: _____

Name: _____ Relationship: _____ Age: _____ Gender: _____

Primary Language Spoken in the home: _____

Additional Languages Spoken in the home: _____

Parent/caregiver participation is an expectation of service at All Kids First. Participation may include team meetings, data collection, and implementation and involvement in the implementation of recommended strategies at home and in the community. Your level of involvement will be based on the recommendation of your BCBA and your availability for the commitment. If your attendance at All Kids First Clinic drops below the recommended hours of ABA prescribed by your BCBA you will be required to commit to at least 1 hour of parent/caregiver training per week.

_____: Yes, I understand that parent/caregiver participation is required of me and I will commit to assisting in the therapeutic process. If my child attends less than the recommended hours of ABA therapy a week I will commit to at least 1 hour of parent training per week.

_____: No, I am unable to commit to participating in my child’s programming at All Kids First due to prior commitments.

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Client profile

What are 3 major concerns you would like to be addressed through ABA therapy?

_____

_____

_____

_____

_____

_____

_____

_____

Please describe any behavior issues your child has (e.g., self-injurious, aggressive towards others, etc.) and methods used to decrease behaviors.

_____

_____

_____

_____

_____

_____

_____

_____

Please describe your child’s current communication skills (e.g., sign language, PECS, verbal).

_____

What else would you like us to know about your child? _____

_____

_____

ALL KIDS FIRST EARLY INTERVENTION SERVICES, LLC.
1875 Old Alabama Rd, Ste 1130, Roswell, GA 30076
Tel# (770) 558 6055 - Fax# (678) 302 3453 - info@allkidsfirst.com - www.allkidsfirst.com

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_____

_____

_____

_____

_____

If your family has cultural, religious, ethnic or social beliefs about physical or mental health or illness that you feel would help us in understanding your child and family, please describe below.

_____

_____

_____

_____

_____

_____

_____

At the assessment your assigned BCBA will recommend a weekly number of hours based on your child’s skill levels. Those hours may consist of one-on-one therapy, social skills therapy, or parent consultation. All Kids First wishes to provide high quality ABA therapy that will be both effective and efficient. To do so, we request that you commit to at least 20 hours per week of therapy.

_____: Yes, I understand that at least 20 hours of ABA therapy per week will be required of my child to attend sessions with All Kids First.

_____: No, I am unable to commit to 20 hours of ABA therapy per week.

Please rate the following session times in order of preference with 1 being the most preferred and 4 being the least preferred.

_____ 9:00am-3:00pm (clinic) _____ 3:00pm-5:00pm (clinic)

_____ 9:00am-12:00pm (home) _____ 9:00am-1:00pm (home)

_____ 10:00am-1:00pm (home) _____ 12:00pm-3:00pm (home)

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_____ 12:00pm-4:00pm (home) _____ 1:00pm-4:00pm (home)

_____ 1:00pm-5:00pm (home) _____ 2:00pm-5:00pm (home)

_____ 2:00pm-6:00pm (home) _____ 3:00pm-6:00pm (home)

Which location do you prefer? (check one)

All Kids First – Roswell Clinic _____ All Kids First - Duluth Clinic _____

Home-based _____

All Kids First offers an intensive toilet training program. Would you be interested in this service if deemed appropriate by your BCBA? ( ) Yes or ( ) No

Medical Information

Child’s Primary Health Care Doctor’s Name: _____ Phone: _____

Autism Diagnosis Information If your child does NOT have an autism diagnosis, but IS on a waiting list or has an appointment for an autism evaluation, please check next to the lines below:

_____No appointment, but on wait list for evaluation with: _____

_____Has appointment with: _____ on this date: _____

If your child HAS an autism diagnosis, please fill out the line below:

My child was diagnosed by: _____

Phone number of person who diagnosed: _____

Date of diagnosis: _____

Please list any current health conditions below (i.e., currently illnesses, allergies, asthma, seizure disorders, etc.)

_____

_____

_____

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What Medications (prescribed and over the counter) does your child currently take?

Name: _____ how often:_____

Name: _____ how often:_____

Name: _____ how often: _____

Name: _____ how often: _____

Name: _____ how often: _____

Name: _____ how often: _____

Does your child have any allergies? (list them below)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any special instructions if your child comes in contact with any allergens or experience an allergic reaction to any of the above? _____

_____

_____

_____

Current School Placement

Name of School: _____ Years attended: _____

Address: _____

Placement: _____

Phone: _____ Hours in school per week: _____

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Current and Previous Educational Services (Speech, OT, PT, etc.)

Name of Provider: _____ Years attended: _____
Address: _____ Service Provided: _____

Phone: _____ Hours in therapy p/wk: _____

Name of Provider: _____ Years attended: _____

Address: _____ Service Provided: _____

Phone: _____ Hours in therapy p/wk: _____

How did you hear about ALL Kids First? (circle)

Internet

Newspaper

Flyer/Brochure

Event (name) _____

Company (name) _____

Person (name) _____

Would you like us to send information about AKF Academy K-5? _____

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