PLS Therapy & Learning Center

CONFIDENTIAL

Today's Date: _____

Name of person completing this form _____
Last First (Relation to client)

CLIENT INFORMATION

Legal Name of Client _____
Last First Nickname

Client's birth date ____/____/____ Age Sex [ ] M [ ] F Height_____Weight _____

Home Address _____
City Zip

With which race/ethnicity do you most identify? (Check all that apply)

	Asian
	Black/African (Non-Hispanic)
	Caucasian (Non-Hispanic)
	Hispanic/Latino
	Multi-racial
	Native American
	Pacific Islander/ Native Hawaiian
	Not listed (please specify):

How did you hear about our Center?

	Web Search
	Event
	Pediatrician/Doctor
	Friend
	Family
	Colleague
	Current PLS Client
	Not listed (please specify):

FAMILY INFORMATION

Mother's Name_____DOB: _____

Address (if different from client): _____

Occupation: _____

Employer_____Work # _____

Does job require you to be away from home for long hours or extended periods? _____

Education Completed:

[ ] Some High School
[ ] High school graduate or equivalent (GED)
[ ] Trade/technical/vocational training
[ ] Some college
[ ] Associate degree
[ ] Bachelor's degree
[ ] Master's degree
[ ] Professional degree
[ ] Doctorate degree

Father's Name_____DOB: _____

Address (if different from client): _____

Occupation: _____

Employer_____ Work # _____

Education Completed:

[ ] Some High School [ ] Some college [ ] Master's degree
[ ] High school graduate or equivalent (GED) [ ] Associate degree [ ] Professional degree
[ ] Trade/technical/vocational training [ ] Bachelor's degree [ ] Doctorate degree

Does job require you to be away from home for long hours or extended periods? _____

(Parent/Guardian)	Home #	Cell #	Email
Mother	_____	_____	_____
Father	_____	_____	_____

Marital status of parents:

[ ] Married [ ] Re-Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single

Parent (s) with custody of child: _____

If married, how long have you been married? _____

If divorced, how long have the biological parents been divorced? _____

Has either parent been married before or since? Mother:_____Father:_____

Please list the name(s) of the stepparent(s): _____

If birth parent(s) do not live in the child's home, how much contact does the child have with biological parent(s)?

_____

Is this Client: [ ] Your Biological Child [ ] Step Child [ ] Adopted Child [ ] Foster Child [ ] Other

Persons living in the home:

Name	Age	Relationship	School Grade

FAMILY INFORMATION, CON'T

Siblings living outside the home:

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age: _____

Are there any other people who have a significant role in how the individual is raised? _____

_____

MEDICAL HISTORY

Physician:_____ Phone: _____

Diagnoses: Please list all current diagnoses (check all that apply)

	Diagnosis	Date of Diagnosis	*Diagnosing Professional/Organization*
	ADHD		
	Autism Spectrum Disorder		
	Blindness/Visual Impairment		
	Deafness/hearing impairment		
	Dyslexia/other reading disability		
	Emotional disturbance		
	Intellectual disability		
	Other Health Impaired		
	Physical or Orthopedic Disability		
	Specific Learning Disability		
	Speech/Language Impairment		
	Traumatic Brain Injury		
	Other (please list):		
	Other (please list):		
	Other (please list):		

Psychiatric/Medical History of Biological Relatives:

(CHECK ALL THAT APPLY) Past/present history of the following in your family:	Siblings	Mother	Father	Extended (Maternal)	Extended (Paternal)
Adjustment Disorder					
Alcohol Abuse					
Antisocial behavior					
Anxiety Disorder					
Attachment Disorder					
Autism Spectrum Disorder					
Conduct Disorder					
Bi-Polar Disorder					

(CHECK ALL THAT APPLY) Past/present history of the following in your family:	Siblings	Mother	Father	Extended (Maternal)	Extended (Paternal)
Depression					
Eating Disorder					
Intellectual Disabilities					
Excessive fears (phobias)					
Lying, fighting, stealing, breaking rules					
Motor/Vocal tics; Tourettes					
Obsessive-Compulsive Disorder					
Oppositional Defiant Disorder					
Personality Disorder					
Psychosis/Schizophrenia					
Short attention, distractibility, hyperactivity					
Seizures/epilepsy					
Substance Abuse/Dependence					
Other medical (please list):					
Other psychological (please list):					

PRE-NATAL AND DELIVERY HISTORY:

Did the birth mother receive regular pre-natal care? [ ] YES [ ] NO

Were there any complications with the Pregnancy? [ ] YES [ ] NO If Yes, please provide details:

_____

_____

Was birth at Full Term? [ ] YES [ ] NO If Yes, please provide details:

_____

_____

Type of Delivery: [ ] Spontaneous [ ] Induced [ ] Vaginal [ ] C-Section

Complications? [ ] YES [ ] NO If Yes, please provide details:

_____

_____

Birth Weight:_____lbs._____oz.

Concerns at birth? [ ] YES [ ] NO If Yes, please provide details:

_____

_____

DEVELOPMENTAL HISTORY

List the age at which developmental milestones were achieved:

Babbled: _____
Spoke first words: _____
List first words spoken: _____
Rolled Over: _____
Sat Alone: _____
Crawled: _____
Stood Alone: _____
Walked Alone: _____
Self-fed w/spoon: _____
Toilet Trained: _____

Please indicate if your child used or uses the following:

Pacifier: _____
Thumb/finger sucking: _____
Bottle: _____
Sippy Cup: _____
Open Cup: _____
Utensils: _____

Please rate the development of your child's motor and self-help skills:

Gross Motor (jumping, stairs, ball skills, etc.) [ ] Poor [ ] Fair [ ] Age-appropriate
Fine Motor (grasp, pincer, drawing, scissors) [ ] Poor [ ] Fair [ ] Age-appropriate
Self-help (dressing, feeding self) [ ] Poor [ ] Fair [ ] Age-appropriate

HEALTH

Is the individual currently taking medication? [ ] YES [ ] NO

Medication	Dosage / Time(s)	Prescribing Physician	Purpose	Side effects

SPEECH/LANGUAGE/HEARING

Do others understand your child? [ ] YES [ ] NO

Does your child understand you (ex. Able to follow directions) [ ] YES [ ] NO

List all the languages spoken in the home _____

Are there concerns about the individual's hearing? [ ] YES [ ] NO

Has a hearing assessment been conducted? [ ] YES [ ] NO Date of last assessment: _____

Are there concerns about the individual's vision? [ ] YES [ ] NO

Has a vision assessment been conducted? [ ] YES [ ] NO Date of last assessment: _____

Any childhood illnesses? _____

What reoccurring health complications (if any) does the individual experience (e.g., asthma, allergies, rashes, sinus or ear infections, gastrointestinal problems, seizures, dental problems, etc.)? _____

Has the individual ever had a seizure or unexplained period of unconsciousness? [ ] YES [ ] NO

If yes, please provide details: _____

Has the individual ever had a head trauma or blow to the head that caused unconsciousness or required a medical review? [ ] YES [ ] NO If yes, please explain: _____

SLEEP PATTERNS

Weekdays: Bedtime: _____ Wakes at: _____
Weekends: Bedtime: _____ Wakes at: _____

Does the individual have difficulties falling asleep? [ ] YES [ ] NO

Does the individual usually: [ ] sleep through the night or [ ] wake often

If individual awakens, does s/he get out of bed? [ ] YES [ ] NO

MEALS/DIET

Does the individual have dietary restrictions? What are they? Please describe the diet and mealtime routines of the individual and the extent to which you think these may impact his or her behavior.

_____

_____

Is your child a picky eater, especially regarding food textures?	[ ] YES	[ ] NO
Does your child avoid messy play?	[ ] YES	[ ] NO
Does your child respond negatively to unexpected or loud noises?	[ ] YES	[ ] NO
Does your child hold hands over ears to protect them from sound?	[ ] YES	[ ] NO
Does your child enjoy strange noises or seek to make noise often?	[ ] YES	[ ] NO
Does your child seek movements that interfere with daily routines?	[ ] YES	[ ] NO
Does your child have difficulty paying attention?	[ ] YES	[ ] NO
Does your child get along with other children?	[ ] YES	[ ] NO

CURRENT EDUCATIONAL PROGRAM

Individual's current grade level _____ Current School Name _____

Please list in chronological order previous schools attended:

NAME OF SCHOOL	*DATES ATTENDED*

Has the individual had previous testing (achievement, intelligence, ability, functional, etc.)? [ ] YES [ ] NO

*Please attach copies of any previous testing results.

Name of Test	*Date of Testing*	*Diagnosing Professional / Organization*
Wechsler Intelligence Scale for Children (WISC)		
Stanford-Binet		
Peabody Individual Achievement Test (PIAT)		
The Woodcock Johnson Test of Achievement		
Otis-Lennon School Ability Test		
Other (Please list):		
Other (Please list):		

IQ (if available) Test: _____ Date: _____ Score: _____

Do you feel the individual's academic skill level is appropriate? [ ] YES [ ] NO [ ] UNSURE

Would you like us to address academic skills development? [ ] YES [ ] NO [ ] MAYBE

Is the individual currently receiving Special Education Services? [ ] YES [ ] NO

What are your child's favorite activities, toys, characters from books, TV, movies, etc.?

What do you consider your child's strengths?

What do you consider your child's weaknesses?

EDUCATIONAL HISTORY

Academic difficulties (check all that apply):

Check box, if applicable, for grade level in which difficulty occurred	P	K	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Lack of motivation/effort														
Negative attitude towards school														
Does not ask for help														
Difficulty paying attention														
Problems with multi-step directions														
Poor listening skills														
Unable to follow verbal directions														
Failed a subject														
Repeated a grade														
Reads below grade level														
Poor/undeveloped vocabulary														
Struggles with mathematics														
Difficulty with handwriting														
Poor organizational skills														
Does not complete assignments														
Other (please list):														
Other (please list):														

Please check any special education services the individual receives/has received (check all that apply):

Check box, if applicable, for each grade level	P	K	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
IEP plan														
504 Plan														
Behavior Intervention Plan (BIP)														
Resource room (pull-out part time)														
Shadow or aide														
Occupational Therapy														
Speech/Language Therapy														
School Counseling														
Behavioral/ABA Therapy														
Other (please list):														
Other (please list):														

ACADEMIC INTERVENTIONS

Please check any instructional strategies and/or learning environment interventions provided to the individual:

Check box, if applicable, for each grade level intervention occurred	P	K	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Administer tests in small group setting														
Copy of notes provided to student														
Cues to stay on task/on-task/focusing prompts														
Extended time for assignments														
Extended time for tests														
Frequent breaks														
Individual visual schedule														
Long assignments broken into small segments														
Modified curriculum														
Preferential seating														
Provide verbal encouragement														
Provide a space with minimal distractions														
Proximity control														
Repeat/clarify and/or summarize directions														
Responses to assessments dictated by student														
Second set of books at home														
Shortened assignments														
Tests read to student														
Use of audio or digital format for presentation														
Use of calculator														
Other (Please list):														
Other (Please list):														

Please provide provider name and dates for previous therapies in school and privately

(ABA, Speech, Occupational, Physical, etc.)

Additional Concerns:

BEHAVIORAL DIFFICULTIES OUTSIDE SCHOOL SETTING

What are the behaviors of concern at home?

Problem Behavior	Estimated Frequency	Estimated Duration	Estimated Severity
	☐ 1-5x /week ☐ 6-10x /week ☐ >10x/week	☐ 1-5 min per event ☐ 6-10 min per event ☐>10 min per event	☐ Low ☐ Medium ☐High
	☐ 1-5x /week ☐ 6-10x /week ☐ >10x/week	☐ 1-5 min per event ☐ 6-10 min per event ☐>10 min per event	☐ Low ☐ Medium ☐High
	☐ 1-5x /week ☐ 6-10x /week ☐ >10x/week	☐ 1-5 min per event ☐ 6-10 min per event ☐>10 min per event	☐ Low ☐ Medium ☐High
	☐ 1-5x /week ☐ 6-10x /week ☐ >10x/week	☐ 1-5 min per event ☐ 6-10 min per event ☐>10 min per event	☐ Low ☐ Medium ☐High
	☐ 1-5x /week ☐ 6-10x /week ☐ >10x/week	☐ 1-5 min per event ☐ 6-10 min per event ☐>10 min per event	☐ Low ☐ Medium ☐High

Provide a history of the undesirable behaviors and the programs that have been attempted

Problem behavior	How long has this been a problem?	Intervention efforts	How effective was the intervention?
			☐ Effective ☐ Moderately Effective ☐ Not Effective
			☐ Effective ☐ Moderately Effective ☐ Not Effective
			☐ Effective ☐ Moderately Effective ☐ Not Effective
			☐ Effective ☐ Moderately Effective ☐ Not Effective
			☐ Effective ☐ Moderately Effective ☐ Not Effective

Prioritizing:

If you could only work on changing one *problem behavior* at a time, how would you order the behaviors?

1.____

2.____

3.____

4.____

Please list your schedule of availability:

	MON	TUES	WED	THURS
Available times				

PATIENT CONFIDENTIALITY

Patient confidentiality is a top priority at *PLS Therapy and Learning Center*. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I, _____, am unable to be reached, PLS may leave information with the following:

[ ] Other adult(s) in household (Name)_____

[ ] On home answering machine

[ ] On cell phone

[ ] I may be reached at my work number

[ ] May leave a message at work on my voicemail

[ ] Other (please describe) _____

OPT OUT (Initials)_____ In the event that I am unable to be reached, PLS MAY NOT leave information with anyone but myself. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at PLS.

_____ Date _____

Parent/Guardian Signature

_____

Print Name

INFORMED CONSENT

I hereby voluntarily apply for and consent to services by the staff of PLS Therapy & Learning Center. This consent applies to myself, ward, or patient named below. The evaluation specialists(s) will select specific tests and checklists that may include the following: (1) review of psychological/medical reports (2) academic evaluation (3) functional behavioral assessments (4) behavior intervention/treatment plans (5) classroom/home observation (6) vision/hearing screening (7) review of cumulative record. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand that the potential benefits of undergoing these services may include obtaining a professional opinion, reduction of symptoms, and/or increased understanding of functioning of myself, my family, and/or my child. I understand that potential risks may include predictive validity of assessments (when applicable), and possible disagreement with the opinions offered to me. I understand that alternative procedures include services provided by another professional. I understand that I may ask for a referral to another professional if I am not satisfied with the progress of treatment.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

The services that PLS Therapy & Learning Center provides are best provided in an atmosphere of trust. All services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Florida and Federal law and our professional codes of conduct/ethics.

TO PROTECT THE CLIENT OR OTHERS FROM HARM

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, an intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

PROFESSIONAL CONSULTATIONS

Behavior Analysts routinely consult about cases with other professionals. In doing so, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. Unless you object, we do not typically tell clients about these consultations; however, these consultations will be so noted in your Private Health Information. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign and Authorization that specifies what information can be release and with whom it can be shared.

I certify that I have read and fully understand the Informed Consent given above and agree to have my child receive services provided by PLS Therapy & Learning Center. Permission is given voluntarily and without coercion or undue influence. It is understood that I may discontinue participation at any time. I will be provided a signed copy of this consent form.

_____ Date _____

Parent/Guardian Signature

_____

Print Name

_____

Name of individual receiving services

Insurance Reimbursement Form

Client's Information:

Name:_____

Date of Birth_____Gender:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone Number:_____

Diagnosis: _____

Insured's Information:

Insurance Company:_____

Identification Number:_____

Group/Plan Number:_____

Employer: _____

Insured's Name:_____Insured's date of Birth:_____

Insured's Gender:_____Insured's Email:_____

**Please provide us with a copy of the front and back of your insurance identification card.*