



Autism Behavior Consultants

“Helping Children Reach Their Potential”

Client Enrollment Application

Date: _____ Referred by _____

Child's Name: _____
 First Initial Last

Date of Birth: _____ Age: _____ Male Female

Child's Current Living Situation

Mother's Name: _____ Mother's occupation _____

Father's Name: _____ Father's Occupation _____

Home Address: _____

City _____ State _____ Zip _____

“X” in box indicates preferred method of contact:

☐ Home Phone: _____

☐ Mobile: _____ (Mother)

☐ Mobile _____ (Father)

☐ E-Mail: _____ (Mother)

☐ E-Mail: _____ (Father)

☐ Fax: _____

Siblings: (Please list whether Sibling Lives in Home)

Name: _____

Age: _____ Grade _____ Full/Half/Step _____

Name: _____ Age: _____

Age: _____ Grade _____ Full/Half/Step _____

Name: _____ Age: _____

Age: _____ Grade _____ Full/Half/Step _____

List any other occupants of child's residence NOT listed above:

What languages does the child use? (List PRIMARY language first): _____

What other languages is your child exposed? _____

If child does not live with BOTH biological parents, who has legal custody of the child?

How often does the other biological parent see this child? _____

Child's Caregiver:

Name: _____ Relationship to child: _____

Phone Number _____

Regional Center Information (California Only)

Is child a client of Regional Center? _____ If yes, which regional center? _____

Please list name and number of your child's Regional Center Case Worker

Child's Current Diagnosis: _____

Diagnosed By: _____

Date Diagnosed: _____ Age of Diagnosis: _____

Pediatrician: _____

Other Doctors/Specialists: _____

Medication History

Child's Current Medications

Name of medication Dose & Frequency Date Started Reason Effectiveness

Utah School Enrollment Only

Immunization/Records (Please Attach)

School History

School District: _____

Current School: _____

School Address: _____

Teacher's Name & Room Number _____

Grade level: _____ Type of class: Regular Ed Special Ed SDC ED RSP

Current # of: Students ____ Teachers ____ Aides ____ Does your child have a 1:1 Aide? _____

Is your child receiving any special education services at school? Yes No

Please list all of the schools, including preschools, your child has attended: _____

Additional Services

Speech therapy	Provided by: _____	Age when began: _____
Occupational therapy	Provided by: _____	Age when began: _____
Physical therapy	Provided by: _____	Age when began: _____
Adaptive Physical Education	Provided by: _____	Age when began: _____
Social Skills	Provided by: _____	Age when began: _____
Other Therapies	Provided by: _____	Age when began: _____

Has your child received prior ABA/DTT treatment from another provider or through the school district? ڻ Yes ڻ No

If so, please explain type, duration, and by whom: _____

Do you currently have funding for ABA? ڻ Yes ڻ No

If so, please detail source and how many hours of therapy per week: _____

Are you requesting a Behavioral Assessment? ڻ Yes ڻ No

If yes, when will you need by? _____

Please fill out the client schedule of availability on the following page. Please block out any time that your child is NOT available to receive ABA services. List all reasons, such as: school, Speech, OT, Funding etc.

Child's Current Schedule

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 AM							
8:30 AM							
9:00 AM							
9:30 AM							
10:00 AM							
10:30 AM							
11:00 AM							
11:30 AM							
12:00 PM							
12:30 PM							
1:00 PM							
1:30 PM							
2:00 PM							
2:30 PM							
3:00 PM							
3:30 PM							
4:00 PM							
4:30 PM							
5:00 PM							
5:30 PM							
6:00 PM							
6:30 PM							
7:00 PM							

Sample

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 AM	Not		School		School		Available
8:30 AM	Available		8-12		8-12		All day
9:00 AM			Home by		Home by		
9:30 AM			12:30	OT	12:30		
10:00 AM			Shadow	10-11	No Shadow		
10:30 AM			Needed	Leave at 9:30	Needed		
11:00 AM				Home by 11:30			
11:30 AM							
12:00 PM							
12:30 PM							
1:00 PM							
1:30 PM		Pick up sister					
2:00 PM		1:30-2:30					
2:30 PM		Nap	Nap	Nap	Nap	Nap	
3:00 PM		2:30-3:30	2:30-3:30	2:30-3:30	2:30-3:30	2:30-3:30	
3:30 PM							
4:00 PM		Speech					
4:30 PM		4-5 at home		Soccer Practice			
5:00 PM				5-6			
5:30 PM				Leave at 4:30			
6:00 PM				Home by 6:30			
6:30 PM							
7:00 PM							