Dear Parent,

Thank you for choosing Achievements Therapy to help you meet the needs of your child. The attached packet will help inform you about Achievements Therapy LLC policies and procedures and allow you time to gather information prior to your intake appointment.

Our approach to working with each child is completely positive, focuses on building skills and is individually tailored to meet each child's need. We focus on keeping your child motivated to learn and achieve. Our goal is to use the most clinically proven treatment to help your child reach new heights.

Our curriculum focuses on understanding and using language, building social skills and communicating and relating to peers and adults. We work on building apparent age appropriate play and leisure skills and increase conceptual thinking and cognitive skills.

Achievements Therapy trained therapists work one-on-one with each child. Our therapists are Registered Behavior Technicians. Supervision of each child's program is provided by a Board-Certified Behavior Analyst who is responsible for the program, its development, staff training, implementation and monitoring.

We additionally offer weekly parent trainings to help your child achieve. Our focus is on helping your child gain skills in language and social areas using state-of-the-art behavioral interventions.

We believe your child can achieve and look forward to helping him/her reach great heights!

Kindly call 877- 733-7033 for further information.

730 Peachtree Street NE, #570 Atlanta, GA 30308-1244
877-733-7033 |
info@achievementstherapy.com | www.achievementstherapy.com

ACHIEVEMENTS
ABA THERAPY

CLIENT INTAKE FORM

This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of time. Please feel free to add any additional information that may be helpful in understanding your child.

PLEASE PRINT

Name of Person Completing this form: _____

Legal Name of Child/Adolescent: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth:_____Age: _____

Allergies / Medical Conditions: _____

Parent(s) / Guardian(s): _____

Home Address: _____

Telephone Number: _____

Work Phone(s) Mother: _____

Father : _____

Mobile Phone(s) Mother : _____

Father : _____

Email: _____

School Name:_____District:_____Grade: _____

School Telephone Number: _____

Current Teacher(s): _____

Who referred you? _____

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ACHIEVEMENTS
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Insurance Reimbursement Form

Child's Name:_____

Date of Birth_____Gender:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone Number:_____

Diagnosis:_____Date of Diagnosis: _____

Diagnosed By: _____

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. *A prescription blank or letter from your child's doctor (primary or specialist) with the diagnosis code AND note that ABA Therapy is required must be provided in order to obtain health insurance approval. *Most health insurance companies also request formal documentation of autism diagnosis from a medical provider's office.

ALLERGIES/MEDICAL HISTORY

Name of child's physician(s) _____

Practice Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Does your child have an ASD (Autism Spectrum Disorder) diagnosis? _____

Name of provider that gave diagnosis: _____ Contact (_____)_____-_____

List any operation, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had. List any medications your child is currently taking or has taken for extended periods (give dosage level if possible):

_____

_____

_____

Please check all that apply to client:

- ☐ Danger to self
- ☐ Danger to others
- ☐ Substance abuse
- ☐ Aggressive behavior
- ☐ Impulse behavior
- ☐ Daily living problems
- ☐ Psychosis/delusions
- ☐ Anxiety
- ☐ Mood disturbance
- ☐ Social interactions
- ☐ Community awareness
- ☐ Cognitive issues
- ☐ Daily living problems
- ☐ Did the client sustain any injuries or physical trauma? If yes, please describe

  _____
- ☐ Was the client ever hospitalized? If yes, please explain

  _____

☐ Does the client have any allergies? If yes, please describe the source of allergic reaction and any adverse reactions.

_____

Note: Achievements Therapy staff are NOT trained to or responsible for administering allergy medications. Achievements Therapy staff do NOT carry or store any allergy medications.

☐ Was an FBA conducted? If yes, please attach copies of any available functional behavioral assessments.

☐ Has an Individualized Education Program (IEP) been developed? If yes, please attach copies of any available Individualized Education Program.

☐ Are there any spiritual or cultural variables that may impact treatment? If yes, please describe

_____

☐ Are there any legal issues that may impact treatment? If yes, please describe

_____

REASON FOR REFERRAL Area(s) of Concern:

- Behavior: _____
- Social Skills: _____
- Language: _____
- Self-Help / Functional: _____

Parent Communication Preference Form

From time to time it may be necessary for your ABA Therapist to contact you regarding scheduling, changes in schedule, delays, or cancellations. In order that we may best meet your communication preferences, please complete and return this form to your ABA Therapist for their records. A copy will also be kept in your child's file. Thank You!

Child Name: _____

Parent Name: _____

Cell Phone: _____

Email: _____

Home Phone:_____

Other: _____

Please Indicate Communication Preference(s):

You may number in order of preference or if no preference, simply place a check in the correct box.

☐ Phone Call to Cell

☐ Email

☐ Phone Call to Home

☐ Text

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