1022 Jones Rd Ste 2 Springdale, AR 72762
Phone: 479-318-2300 Fax: 479-763-0059
www.learningandbehavior.org
info@learningandbehavior.org

CLIENT PRE-ASSESSMENT PACKET

Thank you for your continued interest in receiving services from Learning and Behavior Solutions, Inc. We enjoyed meeting with you and look forward to many more.

As part of the initial in-take process, we ask that you complete the following documents as part of the pre-assessment process.

You may complete and fax, email or mail the completed packet to the contact information above, or simply have it ready to provide during the assessment time.

This information will assist us in expediting the assessment and pre-authorization for treatment, so we might begin to serve your child's needs sooner.

Thank you, again! We look forward to working with you!

Sincerely,

Tiffany K Mrla, PhD
BCBA Certificate # 1-14-10413

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Requirements to Begin Applied Behavioral Analysis (ABA) Services:

1. **Complete Intake Packet and return to Learning and Behavior Solutions via mail, email, fax, or make arrangements to deliver in person.**

   Learning and Behavior Solutions, Inc.
   1022 Jones Rd Ste 2
   Springdale, AR 72762

   Email: tmrla@learningandbehavior.org
   Fax: (479) 763-0059

2. **Provide Insurance Information.** Please include private insurance and any other public insurance info (i.e. Tefra, AR Kids, etc.)

3. **Sign consent for services, financial agreement, and acknowledgment of description of services forms.**

4. **Provide Diagnostic and Evaluation information.**
   - *Speech Therapy Evaluation by licensed therapist with specialized training*
   - *Licensed Child Psychologist report indicating diagnosis of autism*
   - *Report from a developmental pediatrician, pediatric neurologist, or child psychiatrist*
   - *Sensorimotor Evaluation*
   - *An audiological evaluation*
   - *A copy of the school IEP and Behavior Support Plan, if applicable*

   ******Within the required evaluation reports, an adaptive behavior assessment (Vineland, ABAS), an autism-specific assessment (ADOS, CARS, SRS), and cognitive assessment (IQ) are required by insurance companies; school-based evaluations are not accepted for this component******

5. **Contact Learning and Behavior Solutions Inc. to schedule evaluation.** Evaluations for ABA take from 2-3 hours. Please plan to come 15 minutes prior to complete paperwork and plan to stay with your child for the full amount of time. Once the evaluation report is complete, we will discuss recommendations for a plan of treatment and schedule therapy. *A pre-assessment packet will be provided to complete prior to the assessment.*

******We will assist with obtaining the required components, if you complete the Release of Information form at the end of the document for each physician, therapist, etc. that you have worked with regarding your child's diagnosis******

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An Overview of Learning and Behavior Solution's Approach to ABA

Our approach to working with each child is designed to meet each INDIVIDUAL child's unique needs with a focus on:

- the principals of positive reinforcement
- the acquisition, maintenance, and generalization of skills
- identifying and maintaining motivation for learning and engagement
- using data-based decision making processes and evidence-based practices

The curriculum addresses the core issues common in autism spectrum disorders, and other developmental disorders, identified as essential components by the National Academy of Sciences:

- understanding and using language through the development of language skills *(vocal, symbolic, and augmentative)*
- enhancing social skills and daily social interactions
- communicating with and relating to peers, adults, and family
- engaging in age appropriate and symbolic play skills
- increasing conceptual thinking, academic, and cognitive skills

Learning and Behavior Solutions' trained behavior analysts and technicians work one-on-one with each child, closely monitoring behavioral responses in order to reach mastery of the material through methods of instruction tailored to the child's ability level and rate of learning. All of our behavior technicians have achieved a bachelor's degree, or are completing coursework for a degree in the field of study, with equivalent extensive training specifically in evidence-based treatments for autism spectrum disorders. In addition to meeting the minimum requirements for behavior technicians, our behavior technicians are required to be Registered Behavior Technicians (RBT), as certified by the Behavior Analyst Certification Board (BACB). Our goal ensuring each individual child's plan is implemented by skilled and experienced technicians is evident in making the training and continuing education of our technicians a priority. Learning and Behavior Solutions maintains a much higher standard for its staff than law requires, to ensure we provide the best possible services for each child and family. Supervision of each child's program is provided by one of our Board Certified Behavior Analysts (BCBA) or Board Certified Assistant Behavior Analysts (BCaBA), with regular progress reviews weekly.

In addition to the individual ABA/Verbal Behavior Analysis program, parent training, programs to address problem behaviors and a range of behavior analytic services are offered through our In-home, clinic, school and community programs. Our focus is on helping your child gain skills in language, cognitive, academic and social areas through the use of state-of-the-art evidence-based interventions.

We provide behavioral assessments, parent & staff training, program supervision, and various other services to meet each child's needs. Each of our program supervisors is board certified by the Behavior Analysist Certification Board™.

Please call 479-310-6505 for further information or clarification.

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Financial Information

Learning and Behavior Solutions is an in-network provider for Blue Cross Blue Shield of Arkansas, Aetna, Cigna, QualChoice and United/Optum. If you have another insurance carrier, please contact us and we can explore taking the necessary steps to becoming and in-network provider for your insurance carrier.

It is our policy to provide statements for families for co-payment monthly. However, copayments or co-insurance required by your insurance provider are due at the time of the session. For your convenience, we will provide you with an automatic debit/credit card authorization to charge your card the required copayment for each therapy session. You may also provide a check that covers copayment for a week of scheduled services. There is a $25 Returned Check fee for all checks returned by the bank.

Information Related to Scheduling and Sessions

Each case has ABA Registered Behavior Technicians (RBT) designated as the lead person for your family. Each Associate has experience providing services to children with Autism. All cases are overseen by a Board Certified Behavior Analyst or Board Certified assistant Behavior Analyst.

Sessions for in-home or clinic services are typically scheduled for a duration of at least three hours. Current research indicates that longer sessions result in greater retention. This ensures convenient scheduling for all parties. We will work with each individual family to ensure scheduling meets your needs.

A parent or legal guardian is required to be present and available in the home throughout the therapy session(s).

Except in cases of emergency, 24-hour notice is required for all cancelled appointments. Payment for the appointment is required for all missed appointments not cancelled according to this policy. Insurance carriers are not responsible for missed appointment fees. We request that families give us at least two-week notice on significant changes in their plans for ABA sessions scheduling in order to facilitate consistency in service delivery.

The universal standard for therapy, be it the insurance standards or the professional standards of various organizations, such as BACB, APA, ASHA, etc., is that a therapy: "hour" is 45-50 minutes of direct contact with the patient with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. Typically, for a 3-hour in-home therapy session, our staff take ~10 minutes to arrange the materials prior to commencing direct therapy with the child and ~ 15 minutes at the end to record data, tidy the setting, and discuss the session with the parent.

The standard of care outlined in the BACB's Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 2nd Edition (http://bacb.com/wp-content/uploads/2016/08/ABA_Guidelines_for_ASD.pdf) includes supervision of behavior technicians on an ongoing basis, program consultation, program review, and program revision of services performed by a BCBA. These services are necessary for a program to meet minimum professional standards and are not optional.

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Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regards to the use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding, unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

SERVICES OFFERED

We will provide services specifically designed to help you and your child. If not able to meet your child's individual needs, our staff will assist with referrals to other professionals. Our behavioral services consist primarily of individual assessments (behavioral evaluations), training, in-home and in-school consultations and observations, long-term ABA service provision to youth in the autism spectrum, and short-term consultations with individuals, parents, educators, and other related professionals.

APPOINTMENTS

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to our staff personally and give as much notice as possible to cancel or reschedule. This will allow us to offer your time to another person. You may be charged the standard hourly rate (see below) for appointments missed or cancelled with less than 12 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Services are best provided in an atmosphere of trust. Because trust is so important, 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 Arkansas and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

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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, and 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 so doing, 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. We will tell clients about these consultations. 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 an Authorization that specifies what information can be released and with whom it can be shared.

FEES

BCBA hourly fee is $150-200 per hour for consultations, meeting, and therapy. Assessments are typically between 3-5 hours, scheduled over multiple visits. BCaBA rates range from $75 per hour. Our hourly fee for ABA Behavior Technicians is $60 an hour. Please call for travel rates for services provided more than 30 miles from 72762.

HEALTH CARE INSURANCE

If we file your insurance claims, you are responsible for co-payment and additional fees.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions and by the ABA tutor. While the contents of personal notes vary from client to client, most are anecdotal notes related to progress and future goals, reference to conversations, and hypotheses of the professional.

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PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures noted in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

CONTACTING US

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends.). If you are difficult to reach, please leave some times when you will be available. Because of the nature of the services we provide, we do not provide on-call coverage 24 hours per day, 7 days a week. **In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.**

RELEASE FROM LIABILITY

"Behavioral and Learning Solutions (the "Company") cannot and does not guarantee a particular result in this engagement. It will use reasonable efforts to provide requested services in a timely fashion. _____ , "the Client", as guardian of the child, _____, agrees that the Company will not be liable for any damages, whether direct or consequential, that the Client or the child may suffer as a result of the engagement or which may otherwise arise out of, or relate to, any services provided to the Client, child and/ or family. The Client (and its successors and assigns), in order to induce the Company to provide the Services, hereby releases the Company from any claims for damages that may arise relating to the Services rendered to the Client and Counsel."

INFORMED CONSENT FOR SERVICES:

I hereby voluntarily apply for and consent to services by Learning and Behavior Solutions Inc. This consent applies to myself, ward, or client named below. 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 and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below: (1) where abuse or harmful neglect or children, the elderly, or disabled or incompetent individual is known or reasonably suspected: (2) where such information is necessary for the company to pursue payment for services rendered; (3) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist; (4)where the client is examined pursuant to a court order. I hold Learning and Behavior Solutions Inc. harmless for releasing information under the above conditions.

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Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians is required.

_____ _____

Client or Child's name **Date**

_____ _____

Parent/Guardian #1 name **Parent/Guardian #2 name**

_____ _____

Parent/Guardian #1 signature **Parent/Guardian #2 signature**

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Permission to Photograph

I give permission and consent for Learning and Behavior Solutions Inc. to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations. Photographs will **NOT** be used for any marketing purposes nor posted on and social media platforms.

Child's name: _____ Date of birth: _____

_____ _____ Date: _____

Print Name (parent/guardian) Signature (parent/guardian)

Permission to Videotape or Audiotape

I give permission and consent for Learning and Behavior Solutions Inc. to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Learning and Behavior Solutions Inc. and the family.

Child's name: _____ Date of birth: _____

_____ _____ Date: _____

Print Name (parent/guardian) Signature (parent/guardian)

In addition to the above, I also give permission for Learning and Behavior Solutions Inc. to use recorded video segments to present to parents and professionals for conferences and/or other training purposes.

_____ _____ Date: _____

Print name (parent/guardian) Signature (parent/guardian)

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SOCIAL & DEVELOPMENTAL HISTORY

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Learning and Behavior Solutions Inc. will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines, FERPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

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: _____

Home Address: _____
Street

_____ _____ _____ _____
City County State Zip

Home Telephone Number: ___-___-____ Work Phone(s) Mother: ____-____-_____
Father: ____-____-_____

Cellular Phone(s) Mother: ____-___-____
Father: ____-___-____

Other Guardian/Caregiver phone: ____-____-_____

School Name: _____ System: _____ Grade: _____

School Telephone Number: _____

Current Teacher(s): _____

Who referred you to our practice? _____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

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FAMILY INFORMATION:

Marital Status: Married – Remarried – Divorced – Separated – Widowed – Single – Cohabitants

- If divorced, who has physical custody? _____ Is it full or joint?_____
- Who has legal custody? _____ Is it full or joint? _____
- If divorced, please provide a copy of the custody agreement.

Mother's Name (or other guardian):_____
Date of Birth: _____ Age: _____
Occupation: _____ email:
Employer: _____
Education Completed _____ Health: ___Excellent ___ Good ___ Fair ___ Poor

Does either parent's job require him/her to be away from home long hours or extended periods?

_____

Father's Name _____
Date of Birth: _____ Age: _____
Occupation: _____ email:
Employer: _____
Education Completed _____ Health: ___Excellent ___ Good ___ Fair ___ Poor

SIBLINGS:

Name	Age	Relationship	Living in home	School	Grade
_____	_____	_____	Y/N	_____	_____
_____	_____	_____	Y/N	_____	_____
_____	_____	_____	Y/N	_____	_____
_____	_____	_____	Y/N	_____	_____

Please list additional siblings in the above format on the back of this page.

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Has the child you are seeking services for been evaluated in the past? Yes/No
If Yes, please list the following information on the previous evaluation(s)

Who	Type	When	Copy Available
_____	_____	_____	Y/N
			Y/N
_____	_____	_____	Y/N
_____	_____	_____	Y/N

(If more evaluations need to be listed please use the space on the back of this page.)

If yes, what were their general findings and recommendations?

_____

_____

_____

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

PRE-NATAL & DELIVERY:

Were there any complications with the Pregnancy? Y/N

_____

_____

_____

If Yes, please provide treatment details:

_____

_____

_____

Concerns at Birth? Y/N

If Yes, please provide detail – including any treatments given (Additional space on back if needed):

_____

_____

Is there any additional pre-natal or birth information that might be of assistance to us?

_____

_____

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DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

   Said 1st Word Intelligible to strangers _____

   Said two-three word phrases _____

   Used Sentences regularly _____

   Toilet trained during the day _____

   Dry through the night (6+ months) _____

   Dressed Self _____

2. Please indicate if your child is experiencing any of the following:

   Problems with eating _____

   Isolated socially from peers _____

   Problems making friends _____

   Problems keeping friends _____

   Problems controlling temper _____

   Problems sleeping through the night _____

   Nightmares _____

   Bed Wetting _____

   Anxiety _____

   Unmotivated _____

   School concentration difficulties _____

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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):

_____

_____

_____

_____

With which hand does the child write: _____

Does the child have any vision problems? _____

Does the child have any hearing problems?

_____

_____

Name of child's physician(s) _____

Practice Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

(Please list information on additional Physicians on the back of the page)

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EDUCATION HISTORY:

1. List the schools you child has attends:

Name	System	Year(s)	Grade	Special Ed?
•				
•				

2. Name(s) of current teacher(s) _____

3. Does your child's teacher have concerns about him/her (list) _____

   _____

4. What is your child's favorite subject/class? _____

5. What is your child's least preferred subject/class? _____

6. Has your child ever repeated a grade? Y/N If yes, what grade(s)?: _____

7. If your child has been in Special Education, did they have a:

- ☐ 504 Plan
- ☐ I.E.P.
- ☐ Psychological Evaluation
- ☐ Special Evaluation
- ☐ Behavior Intervention Plan
- ☐ Other(s)
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Adaptive Technology Evaluation

---

8. If your child has been in Special Education, how were they served?

- ☐ Consultation
- ☐ Collaborative Education
- ☐ Pull-Out
- ☐ Special Program
- ☐ Resource Classroom
- ☐ Team Taught Classes
- ☐ Self-Contained Classroom

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9. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

☐ Football	☐ Piano	☐ Gymnastics
☐ Baseball	☐ Scouts	☐ Other_____
☐ Cheerleading	☐ Soccer	☐ Other_____
☐ Basketball	☐ Dance	☐ Other_____
☐ Karate	☐ Music	☐ Other_____

10. List any special abilities, skills, strengths your child has: _____

_____

DISCIPLINE INFORMATION:

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

Intervention	Very Unlikely				Very Likely	Effectiveness
Let situation go	1	2	3	4	5	_____
Take away a privilege (i.e., no TV)	1	2	3	4	5	
Assign an additional chore	1	2	3	4	5	_____ _____
Take away something material	1	2	3	4	5	_____ _____
Send to room	1	2	3	4	5	
Reason with child	1	2	3	4	5	_____ _____
Ground/ Time Out	1	2	3	4	5	
Argue/ Yell	1	2	3	4	5	_____ _____
List anything else you may do:						
	1	2	3	4	5	
_____	1	2	3	4	5	_____ _____
_____	1	2	3	4	5	_____ _____

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective. Please rate what percentage of discipline is handled by each of the following:
Father:_____% Mother:____% Other: _____% (Please Specify:)_____

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GOALS:

Please list the **five** things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sister, etc.

	Like Child to do More Often	Like Child to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

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ACADEMIC:

Do you feel your child's academic skill level is appropriate? Y/N
Would you like us to address academic skills development? Y/N

Can your child identify letters?
Lowercase ☐ all ☐ some ☐ none
Uppercase ☐ all ☐ some ☐ none

Can your child identify numbers?
Single digit (1-9) ☐all ☐ some ☐ none

Counting:
Can count to 10 ☐Yes ☐No Can count to 20 ☐Yes ☐No Can count 20+ ☐Yes ☐No

Can your child count out a number of objects (e.g. Give me four pennies)
Up to 5 objects ☐Yes ☐No Up to 10 objects ☐Yes ☐No 10 + objects ☐Yes ☐No

Can your child identity double digit numbers? 10-99 ☐ all ☐some ☐ none

Can he/she complete simple addition math problems? (Single digit) ☐Yes ☐No

Can he/she complete simple subtraction problems? ☐Yes ☐No

Letter sounds:
Can your child: Identify letter sounds ☐all ☐some ☐none
Identify blends (e.g. sh, st, cr) ☐Yes ☐No Can sound out words with blends ☐Yes ☐No

Reading:
Can read simple words (2-4 letter simple words – cat, dog, sat) ☐Yes ☐No
Can read longer words and sight words (there, just, jump) ☐Yes ☐No
Can sound out unknown words ☐Yes ☐No
Can read simple sentences ☐Yes ☐No
Can comprehend what he/she is reading (can understand and answer questions about what's been read) ☐Yes ☐No

Other number skills:

Reading Comments:

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SELF-CARE:

Does your child dress him/herself?
☐Independently ☐with some assistance ☐does not dress self

Does your child bathe him/herself?
☐Independently ☐with some assistance ☐does not bathe self

Grooming (brushing teeth, combing hair)
☐independently ☐some assistance ☐does not

Does your child clean up after him/herself
☐independently ☐when asked ☐does not

Do you have safety concerns regarding your child's activities at home? ☐Yes ☐No
Explain: _____
_____

ATTENDING/ENGAGEMENT:

Does your child make eye contact with others ☐always ☐sometimes ☐never
Answer or look when name is called ☐always ☐sometimes ☐never

Respond with distraction:
Can your child answer questions when there is background noise, other people, distraction?
☐always ☐sometimes ☐rarely

Auditory processing:
Does your child appear to understand directions and questions? ☐strength ☐challenge
Can your child appropriately play by him/herself ? ☐Yes ☐No
Does your child appear to have a good memory? ☐Yes ☐No

Self-Care Comments:

Attending Comments:

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BEHAVIOR:

Physical Stereotypic Behavior:
Does your child flap his hands/arms ☐Yes ☐No
Does your child seem to look at his fingers in a stereotypic way ☐Yes ☐No
Does your child seem to look out of the side of his/her eyes ☐Yes ☐No
Does your child walk on his/her toes ☐Yes ☐No
Does your child rock (sit and rock back and forth) ☐Yes ☐No

Verbal Stereotypic Behavior:
Echolalia – repeats what is said/heard – Immediate ☐Yes ☐No
Echolalia – Delayed – (will repeat what's been said/heard later) ☐Yes ☐No
Self-talk ☐Yes ☐No
Humming to self – inappropriate ☐Yes ☐No
Screech or yell inappropriately ☐Yes ☐No for no apparent reason ☐Yes ☐No

Perseveration:
Does he/she get stuck on a topic ☐Yes ☐No
Develop obsession about specific people ☐Yes ☐No
Develop obsession about specific objects ☐Yes ☐No

Transition/Routines:
Fears:
Struggles with sudden change ☐Yes ☐No
Difficulty with changes that they are warned about ☐Yes ☐No
Does your child fear any specific objects, animals, places or people? ☐Yes ☐No

If yes, explain

_____
_____
_____

Tantrums/Aggression/Self-Injury: Does your child display interfering or aggressive behavior that you feel needs to be addressed? ☐Yes ☐No
Describe behavior:

_____
_____

What triggers such incidents?
When told "no" (you can't have that/can't do that) ☐Yes ☐No
When he/she is not getting attention or wants attention ☐Yes ☐No
To avoid a non-preferred activity ☐Yes ☐No
To escape a non-preferred task/activity ☐Yes ☐No
For no obvious reason ☐Yes ☐No

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Does your child react aggressively at times? ☐Yes ☐No
Describe aggressive behaviors:

_____
_____

Is this behavior disruptive enough that you feel it needs to be addressed? ☐Yes ☐No
What triggers aggressive behavior?
When told "no" (you can't have that/can't do that) ☐Yes ☐No
When he/she is not getting attention or wants attention ☐Yes ☐No
To avoid a non-preferred activity ☐Yes ☐No
To escape a non-preferred task/activity ☐Yes ☐No
For no obvious reason ☐Yes ☐No

Does your child engage in Self-injurious behavior (hurt himself or herself)? ☐Yes ☐No
Describe self-injurious behavior:

_____
_____

What triggers self injurious behavior?
When told "no" (you can't have that/can't do that) ☐Yes ☐No
When he/she is not getting attention or wants attention ☐Yes ☐No
To avoid a non-preferred activity ☐Yes ☐No
To escape a non-preferred task/activity ☐Yes ☐No
For no obvious reason ☐Yes ☐No

SENSORY ISSUES: Does you child have sensitivity to (if yes explain): ☐Yes ☐No
Behavior Comments:
☐Sound ☐Light ☐Touch ☐Texture

Sensory Comments:

_____
_____
_____
_____

IMITATIONS OF MOTOR & SPEECH:

Can imitate movements when they are demonstrated (clap hands, touch head when someone else is doing the same and he/she is asked to "do this" or "clap hands") ☐Yes ☐No
Can imitate motions that go along with a song ☐Yes ☐No
Can imitate a word or words when told to "say ____" ☐Yes ☐No
Imitation Comments:

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SPEECH:

Do you have concerns regarding dyspraxia or apraxia? ☐Yes ☐No
If yes explain _____

Does your child repeat what he/she has heard other people or TV characters say? ☐Yes ☐No **If yes explain** _____

Does your child use a communication system such as PECS, sign, augmentative device, etc? ☐Yes ☐No
If yes explain _____

Speech Comments:

LANGUAGE:

Does your child appear to understand language?
☐not at all ☐a little ☐this is a strength
Words in isolation – can identify objects when asked ☐Yes ☐No
Can identify actions ("where is the boy who is running" when shown a pictures of kids playing) ☐Yes ☐No
Can identify describing words (red vs. blue, big vs. little) ☐not at all ☐a little ☐strength
Can understand simple sentences ("drink your milk.") ☐Yes ☐No
Can understand more complex sentences ("go get your red shoes," or "give me the one that is not wet") ☐Yes ☐No
Can he/she follow directions? ☐Yes ☐No
☐one step ☐two step ☐three step ☐with delay ("after ____, go _____")

Does your child use the following when speaking:

Nouns (people, places and things)	☐sometimes	☐always	☐never
Verbs (action words)	☐sometimes	☐always	☐never
Adjectives (describing words)	☐sometimes	☐always	☐never
Prepositions (in, out, on etc.)	☐sometimes	☐always	☐never
Pronouns (I, you, she, he)	☐sometimes	☐always	☐never
Simple sentences (3-4 word)	☐sometimes	☐always	☐never
Sentences w/descriptors ("It' s a black dog")	☐sometimes	☐always	☐never

Expressive Communication:
Does your child use language?

To request needs/wants	☐sometimes	☐always	☐never
To greet others	☐sometimes	☐always	☐never
To respond to greetings	☐sometimes	☐always	☐never
Answer simple questions (what's your name?)	☐sometimes	☐always	☐never

Language Comments:

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Social/Play Skills:

Does your child seek out social interaction with:

☐adults ☐siblings ☐peers

Does your child play:

Independently ☐sometimes ☐always ☐never
Next to but not with others ☐sometimes ☐always ☐never
With other children ☐sometimes ☐always ☐never
With toys ☐uses appropriately ☐does not play with as intended
Game skills – plays games ☐turn taking independently ☐needs assistance
Verbal skills ☐talks to peers during play ☐talks to self ☐does not talk

Social Comments:

Fine Motor Skills

Is your child ☐ left handed ☐ right handed ☐ no preference
Does your child hold a pencil properly? ☐Yes ☐No
Can he/she:
Trace ☐Yes ☐No Copy letters ☐Yes ☐No Copy words ☐Yes ☐No

Gross Motor Skills

Do you have concerns regarding your child's gross motor skills? ☐Yes ☐No
Explain:

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PARENT/FAMILY PRIORITIES & PREFERENCES

Top three areas/goals you would like to see change for your child in next 6 months:

1.

2.

3.

SUPPORTING BEHAVIORS:

Sometimes when teaching our students appropriate replacement behaviors, students may become upset or cry. When this happens, we are very adept at working through these instances with favorable outcomes. We want to understand how you feel about this when it happens. (Please note that all behavior support plans are discussed with parents and strategies for responding are explained and approved. Providers can debrief parents after any "difficult" sessions as well.)

☐ **I am comfortable with letting my child cry and letting providers handle the situation**
☐ **I am NOT comfortable with letting my child cry and letting providers handle the situation**
☐ **I am unsure at this time**

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AUTHORIZATION TO RELEASE INFORMATION

Client Name:_____ **Birthdate:**_____ **Parent/Guardian Name(s):**_____

Phone: _____ **Work Phone:** _____ **Address:** _____ **City:** _____ **State:** ____ **Zip:** _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Learning & Behavior Solutions, Inc. I understand that my personally identifiable information (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. ***I understand that I may revoke this authorization at any time by notifying Learning & Behavior Solutions, Inc., in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.***

I hereby authorize *Learning & Behavior Solutions, Inc.* to *the parties I have indicated below* (check all that apply):

❒ Exchange with ❒ Release to ❒ Obtain from

I hereby authorize *Learning & Behavior Solutions, Inc.* to exchange / release / obtain information:

❒ Verbally only ❒ In written form only ❒ Both verbally and in writing

As parent or legal representative of the above-named client, **I request that information be released from:**

Name of Facility: *Learning & Behavior Solutions, Inc.*

Phone: *479-318-2300* **Fax:** *479-763-0059* **Email:** tmrla@learningandbehavior.org

To the Attention of: *Tiffany Mrla, PhD, BCBA*

Address: *1022 Jones Rd Ste 2*

City, State, Zip: *Springdale, AR 72766*

To the following:

Name of Facility: _____

Phone: _____ **Fax:** _____ **Email:** _____

To the Attention of: _____

Address: _____

City, State, Zip: _____

Information Requested: *Copies of all progress notes and evaluation information; to include referrals made to other agencies for evaluation, etc.*

Purpose of the requested information: *to work collaboratively in developing a comprehensive treatment plan as we develop ABA services and supports for the named client*

I understand the purpose for which this information is being requested. I also understand that a copy of this request is valid in lieu of the original. This request will expire one year form the date signed. I understand that I have the right to revoke the authorization, in writing, before the expiration date.

Parent/Legal Representative Name: _____ **Relationship to Client:** _____

Parent/Legal Representative Signature: _____ **Date:** _____

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Name of Facility: _____

Phone: _____ **Fax:** _____ **Email:** _____

To the Attention of: _____

Address: _____

City, State, Zip: _____

Name of Facility or Person: *Learning & Behavior Solutions, Inc.*

Phone: *479-318-2300* **Fax:** *479-763-0059* **Email:** tmrla@learningandbehavior.org

To the Attention of: *Tiffany Mrla, PhD, BCBA*

Address: *1022 Jones Rd Ste 2*

City, State, Zip: *Springdale, AR 72762*

Information Requested: *Copies of all progress notes and evaluation information; to include referrals made to other agencies for evaluation, etc.*

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Parent/Legal Representative Name: _____ **Relationship to Client:** _____

Parent/Legal Representative Signature: _____ **Date:** _____