# Client Intake Form

This form is to be completed by the Parent/Guardian of the client of Cusps and Capabilities LLC prior to the initial consultation visit.

## Parent/Guardian Information

| | |
|---|---|
| Parent/Guardian 1 Name:<br>(First, Middle, Last) | |
| Parent/Guardian 1 Email: | |
| Parent/Guardian 1 Phone# | |
| Parent/Guardian 2 Name:<br>(First, Middle, Last) | |
| Parent/Guardian 2 Email: | |
| Parent/Guardian 2 Phone# | |
| Primary Street Address:<br>(Street number)<br>(City, State, Zip) | |
| Emergency Contact Name/Phone # | |

## Child's Information

| | |
|---|---|
| Child's Name (First, Middle, Last) | |
| Child's Date of Birth | |
| Child's Social Security # | |
| Primary Street Address<br>(Street number)<br>(City, State, Zip) | |

## Insurance Information

*A copy of the insurance card at the time of initial visit*

Name of Insurance Company: _____

Name of Policy Holder: _____

Social Security # of Policy Holder: _____

DOB of Policy Holder: _____

Insurance Address: _____

Phone Number: _____

Member ID: _____ Group ID: _____

## Medical Information

Name of physician: _____

Physician address: _____

Physician phone: _____

Does your child have any current health conditions? If so, please explain:

_____

_____

Please provide a detailed description of any allergies you child has:

_____

_____

Please list any medications that your child is currently taking.

| Medication | Dosage | Frequency | Side effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |

Does your child have any diagnoses? If so, please state below.*

| Diagnosis | Diagnosing physician | Date diagnosed | Diagnosis Code |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Educational Information

Does your child attend school? If so, please complete the information below.

Name of school: _____

Classroom Type: _____

Teacher/Grade: _____

Address: _____

School phone number: (_____) _____

***Current/Previous Therapy Provider Information (please attach most recent evaluations)***

**Therapy Type:** _____

Therapists Name/Phone: _____

Dates of Service: _____

Therapy Outcomes:

_____

_____

_____

**Therapy Type:** _____

_____

* Required for insurance coverage

Therapists Name/Phone: _____

Dates of Service: _____

Therapy Outcomes:

_____

_____

_____

**Therapy Type:** _____

Therapists Name/Phone: _____

Dates of Service: _____

Therapy Outcomes:

_____

_____

_____

***Child's Current Behaviors and Expected Outcomes***

Please provide detail regarding the concerns of your child's development, if any:

_____

_____

_____

Please describe any problem behaviors or interfering behaviors of concern:

_____

_____

_____

Please state the expectations/goals that you have for your child while engaging in a behavioral program:

_____

_____

_____

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

_____

_____

_____

Referred by: _____

*Please attach any assessments or evaluations that may aid in developing your child's program and behavioral interventions.