Shaping Change

Client Intake and Consent Form

(Please Print)

CONTACT PERSON INFORMATION	
Contact Person's Name:	**Today's Date**:
Relationship to Client:	**Email**:
Home Phone:	**Cell Phone**:
Address:	

Chose clinic because / Referred to clinic by (please check one box): ☐ Dr. _____

☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Intake Form checklist (FOR OFFICE USE ONLY):

☐ Completed and signed this Intake Form

☐ Attached copy of diagnostic reports/evaluations (must be within last 3 years)

☐ Attached copy of Educational Plan

☐ Attached copy (front and back) of insurance card (color copy)

☐ Attached copy of driver's license (color copy)

Fax completed Intake Form and copies of the above documents to 1(866)-883-9515 or drop off at our office. All information must be received prior to scheduling a consultation. Please do not send Protected Health Information (PHI) through email-we will not accept it.

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The following questionnaire is to be completed by the client, the client's parent or his/her 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 that you think may be helpful in understanding your child. Shaping Change, LLC will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law.

Please use the backs of the pages for additional information.

CLIENT INFORMATION		
Client's Name:	**Date of Birth**:	**Age**:
Gender: ☐ Male ☐ Female	**Race / Ethnicity**: ☐ White ☐ African ☐ Hispanic ☐ Asian ☐ Other	
Address:	**Email**:	
Home Phone:	**Cell Phone**:	
Occupation:	**Employer Name**:	**Employer Phone**:
Employer Address:		

CLIENT PARENTS / GUARDIANS INFORMATION		
Mother / Guardian Name:	**Date of Birth**:	**Age**:
Email:	**Race / Ethnicity**: ☐ White ☐ African ☐ Hispanic ☐ Asian ☐ Other	
Address:		
Home Phone:	**Cell Phone**:	
Occupation:	**Employer Name**:	**Employer Phone**:
Employer Address:		
Education Level Completed: ☐ Elementary School ☐ Middle School ☐ High School ☐ College/University		
Father / Guardian Name:	**Date of Birth**:	**Age**:
Email:	**Race / Ethnicity**: ☐ White ☐ African ☐ Hispanic ☐ Asian ☐ Other	
Address:		
Home Phone:	**Cell Phone**:	
Occupation:	**Employer Name**:	**Employer Phone**:
Employer Address:		
Education Level Completed: ☐ Elementary School ☐ Middle School ☐ High School ☐ College/University		
Are the parents/guardians divorced? ☐ Yes ☐ No (If yes, please provide a copy of the parental responsibility agreement)		

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CLIENT INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of person responsible for bill:	**Date of Birth**:	**Address**:
Home Phone:	**Cell Phone**:	
Occupation:	**Employer Name**:	**Employer Phone**:
Employer Address:		
Is this client covered by insurance? ☐ Yes ☐ No	**Primary Insurance Provider**:	

Subscriber's Name:	**Date of Birth**:	**Group No.**:	**Policy No.**:	**Co-payment Amount**: $
Client's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				
Secondary Insurance Provider:				
Subscriber's Name:	**Date of Birth**:	**Group No.**:	**Policy No.**:	**Co-payment Amount**: $
Client's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				

CLIENT EDUCATIONAL INFORMATION

School Name (In chronological order)	**System**	**Year(s)**	**Grade**	**Special Ed?**

Name(s) of Current Teacher(s):	**List concerns client may have about the teacher(s)**:
Client's Favorite Subject/Class:	**Client's Least Favorite Subject/Class**:
Has client ever repeated a grade? ☐ **Yes** ☐ **No**	**If Yes, what grades?**

If client has been in Special Education, did they have: ☐ 504 Plan ☐ Psychological Evaluation ☐ Behavior Intervention Plan ☐ Physical Therapy Evaluation ☐ I.E.P. ☐ Speech Evaluation ☐ Occupational Therapy Evaluation ☐ Adaptive Technology Evaluation ☐ Other(s)

If client has been in Special Education, how was he/she served? ☐ **Consultation** ☐ Collaborative Education ☐ Pull-Out ☐ Resource Classroom ☐ Team Taught Classes ☐ Self-Contained Classroom ☐ Psychoeducational Center ☐ Special Program

Client's Extracurricular Activities (sports, clubs, hobbies, lessons, etc.): ☐ Football ☐ Baseball ☐ Cheerleading ☐ Basketball ☐ Karate ☐ Piano ☐ Scouts ☐ Soccer ☐ Dance ☐ Music ☐ Gymnastics ☐ Other

Client's special abilities, skills, strengths:

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CLIENT MEDICAL HISTORY INFORMATION

Diagnosis 1 (please provide a diagnosis):

Diagnosing Physician:	**Date of Diagnosis**:

Diagnosis 2 (please provide a diagnosis):

Diagnosing Physician:	**Date of Diagnosis**:

Diagnosis 3 (please provide a diagnosis):

Diagnosing Physician:	**Date of Diagnosis**:

Diagnosis 4 (please provide a diagnosis):

Diagnosing Physician:	**Date of Diagnosis**:

Relevant Hospitalizations:

Were developmental milestones met on time? ☐ Yes ☐ No

Abuse History:

Please list any prescription or non-prescription medication/supplements (if additional space is needed use the same format in the back of this page)

Medication/Supplement	**Dose**	**Frequency**	**Reason**	**Prescribing Physician**

PRESENTING PROBLEM INFORMATION

Please explain client's presenting problem:

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FAMILY INFORMATION

Siblings

Name	Age	Race	Relationship	Living in Home Yes / No	School Name	Grade
				☐ ☐		
				☐ ☐		
				☐ ☐		
				☐ ☐		

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

Please indicate any special needs of concern regarding the other children living in your home:

Please indicate any concerns you have regarding the client for whom you are seeking services and these siblings' relationship(s):

Others – List any other people who currently, or in the client's lifetime, have lived in your home

Name	Age	Race	Relationship to Client	Years Living in Home (from – to)
				–
				–
				–
				–

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SERVICES INFORMATION			
Past Services			
	Yes / No		**Dates of Service (from – to)**
ABA	☐	☐	–
OT	☐	☐	–
Speech	☐	☐	–
PT	☐	☐	–
Counseling	☐	☐	–

Current Services			
	Yes / No		**Dates of Service (from – to)**
ABA	☐	☐	–
OT	☐	☐	–
Speech	☐	☐	–
PT	☐	☐	–
Counseling	☐	☐	–

STATEMENT		
I understand this Client Intake and Consent Form to aid in gathering information for effective treatment. If I choose not to seek services, any paperwork coll Shaping Change, LLC. will be shred after 30 days.		
Name:	**Signature**:	**Date**: