Behavioral Consulting Services

Patient Name:_____
Patient DOB:_____

Parent/Guardian Name:_____

Preferred Method of Contact (Circle one): E-mail Call Text
Email Address:_____
Phone Number:_____
Home Address:_____

Medical Information:
1. Specific diagnosis/diagnoses:_____
2. Date of Diagnosis:_____
3. Diagnosing Physician Name:_____
4. Primary Care Physician Name, Address, Phone: _____
_____

5. Does the client have any other health conditions (If yes, please list below)?: yes/no
_____

6. Does the client take any medications (if yes, please list below)?:_____

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7. Have you received ABA therapy in the past (circle one)? Yes/No
If yes, was it in-home, center-based, or school-based?_____

Behavioral areas of concern (check all that apply):

- ☐ Social/communication
- ☐ Repetitive behaviors
- ☐ Aggression
- ☐ Self injurious

Insurance Information:
1. Insurance Carrier: _____
2. Insurance Phone Number:_____
3. Member ID:_____
-4. Group ID:_____
5. Policy Holder:_____