12913 Lucille
Overland Park, KS 66213
info@abskc.com
913-802-2227 (p) / 913-273-0235 (f)

**Client Information Packet**

Filled out by: ____________________________________________________ Date: _____________
(Name and relationship to client)

Child's Name: ___________________________________ Nickname: _____________________________________

Today's Date: ________ Date of Birth: ______-______-______ Current Age: _______ Gender: ___Male ___Female

Address: ________________________________________________________________________________________

_____________________________________________________________________________________________

Parent/Guardian #1: ____________________________________________ Date of Birth: _____________________

Home Telephone: (_____) ______-_______ Cell Phone: (_____) _____-_______ Work Phone: (____) _____-_______

E-Mail Address: ______________________________________________________________________________

Occupation: _________________________________________________________________________________

Parent/Guardian #2: ____________________________________________ Date of Birth: _____________________

Home Telephone: (_____) ______-_______ Cell Phone: (_____) _____-_______ Work Phone: (____) _____-_______

E-Mail Address: ______________________________________________________________________________

Occupation: _________________________________________________________________________________

Please List All Siblings:

Name: ________________________________ Age: __________ Gender: _______ Live with? ☐Yes ☐No

Name: ________________________________ Age: __________ Gender: _______ Live with? ☐Yes ☐No

Name: ________________________________ Age: __________ Gender: _______ Live with? ☐Yes ☐No

Name: ________________________________ Age: __________ Gender: _______ Live with? ☐Yes ☐No

Name: ________________________________ Age: __________ Gender: _______ Live with? ☐Yes ☐No

Are there others that live in the same home that are not guardians listed above or siblings? ☐Yes ☐No If so please identify those persons and describe relationship to the family:

______________________________________________________________________________________

Family religious preferences and/or religious considerations: ________________________________________

______________________________________________________________________________________

Family cultural preferences and/or cultural considerations: __________________________________________

______________________________________________________________________________________

Families Primary Language: ______________________ Secondary Language: ________________________

**Developmental History**

List any childhood illnesses, (Please list the child's age, the illness, and the treatment prescribed):

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Has your child exhibited sleep issues in the past and do they exhibit sleep issues now? Explain.

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

If yes, what strategies did or are you trying? _________________________________________________

______________________________________________________________________________________

Has your child exhibited any feeding issues in the past and do they exhibit eating/feeding issues now? Explain.

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

If yes, what strategies did or are you trying? _________________________________________________

______________________________________________________________________________________

Describe your child's typical diet. Allergies? Gluten?

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Self Help Skills. Describe your child's general skills in the following areas:

Toileting:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Feeding:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Dressing:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Showering/Bathing:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Medical History**

Diagnosis______________________________________________________________________

Date of Diagnosis_____________________ Diagnosed by: ________________________________________________

List names and addresses of medical professionals involved with the child (Pediatrician, counselor, etc.)

Name Address Phone

1.____________________________________________________________________________

2. ____________________________________________________________________________

3.____________________________________________________________________________

Hospitalizations/Operations/Other Medical Conditions

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

__________________________________________________________________________________

Does your child have seizures? ☐Yes ☐No
If no, has your child had seizures in the past? ☐Yes ☐No
If yes, please indicate frequency of seizures: ____________________Length: ____________Type:________________
Is your child currently taking seizure medication? ☐Yes ☐No
If yes, please list medication(s):

____________________________________________________________________________________

____________________________________________________________________________________

Please list all major medical conditions that run in your family:

____________________________________________________________________________________

____________________________________________________________________________________

Does child take any medications? ☐Yes ☐No If yes, please list dosage, reason for medication and administration details:

____________________________________________________________________________________

____________________________________________________________________________________

Last physical: ___________ Client Height:_______ Weight:___________
Name of Primary Care Physician: _________________________________ Contacted ☐Yes ☐No
Health insurance: ______________________________________________

As well as you can remember, were there any delays in the following areas?

- ☐Sat Alone
  - ☐ Named Colors
  - ☐Rode Bike
  - ☐Stood Alone
  - ☐Began to Read
  - ☐Buttoned clothes
  - ☐Said words
- ☐Toilet Trained
  - ☐Crawled
  - ☐Said Alphabet
- ☐Used Sentences
  - ☐Walked Alone
  - ☐Tied Shoes

Is there a family history of mental health problems? ☐Yes ☐No
Please Specify: _______________________________________________________________

Is there a family history of substance abuse? ☐Yes ☐No
Please Specify: _______________________________________________________________

Is there a history of, or current concern with any of the following?

☐School Behavior Problems ☐Academics

- ☐ Eating Problems
- ☐ Speech Difficulties
- ☐ High temperatures
- ☐ Head injuries/concussions
  - ☐ Poor Memory
- ☐ Wetting Pants
- ☐ Soiling Pants
- ☐ Lying
- ☐ Avoids Cuddling
- ☐ Sleep Difficulties
- ☐ Headaches
- ☐ High Energy
- ☐ Constipation
- ☐ Sex play with other children
- ☐ Aggressive Behavior
- ☐ Legal Problems
- ☐ Fears
- ☐ Attention Deficit Disorder
- ☐ Bizarre Behaviors
- ☐ Stealing
- ☐ Masturbation
- ☐ Elopement
- ☐ Temper Tantrums
- ☐ Crying Spells
- ☐ Cruel to Animals
- ☐ Coordination
- ☐ Truancy
- ☐ Impulsivity
- ☐ Interrupting
- ☐ Poor Attention
- ☐ Bed Wetting
- ☐ Fire Setting
- ☐ Frequent Bad Dreams
- ☐ Defiance to Authority
- ☐ Obsessive Behavior
- ☐ Suicidal Thoughts
- ☐ Hallucinations
- ☐ Other:_________________

What stressors are affecting the client?

- ☐ Home
- ☐ Peer
- ☐ School
- ☐ Grades
- ☐ Other:____________________________
- ☐ Parent Conflict
- ☐ Family
- ☐ Siblings/Step Siblings
- ☐ Step Parent
- ☐ Losses

**Prenatal Information**

Is the client adopted? ☐ Yes ☐ No

If so, at what age? ________________________________________________________________________________

Any circumstances regarding adoption that are relevant? ________________________________________________

During pregnancy, did the mother:

- ☐ Take Medications
- ☐ Drink Alcohol
- ☐ Smoke Cigarettes
- ☐ Use Recreational Drugs

Length of Pregnancy: _________________ Birth weight:_________________ Duration of labor:__________________

Were forceps used? ☐ Yes ☐ No Delivery was (check one) ☐ Normal ☐ Breech ☐ Cesarean

Please inform us of any complications during pregnancy or birth?

______________________________________________________________________________________________

______________________________________________________________________________________________

Infectious Disease
Does your child, or has your child ever had an infectious disease? If so, please list.

________________________________________________________________________________

________________________________________________________________________________

What precautions are currently taken to prevent the spread of the disease?

________________________________________________________________________________

**General Behavior**

Non-Compliance: ☐Yes ☐No
Describe the context in which it usually occurs:

________________________________________________________________________________

________________________________________________________________________________

Consequences Used/Response to:

________________________________________________________________________________

________________________________________________________________________________

Tantrums: ☐Yes ☐No
Describe the context in which it usually occur:

________________________________________________________________________________

________________________________________________________________________________

Describe nature of tantrum (i.e., throws self on floor, etc.):

________________________________________________________________________________

________________________________________________________________________________

Duration of typical tantrum: ____________________________________________________________

Frequency (# daily/weekly): _____________________________________________________________

Consequences Used:

________________________________________________________________________________

________________________________________________________________________________

Aggression: ☐Yes ☐No Towards Self _______ Towards Others _______ Towards Property _______
Describe context in which it usually occurs:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Describe nature of aggressive behaviors:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Frequency: _____________________________ Duration of episodes: ______________________________________
Consequences Used:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Elopement: ☐Yes ☐No
Describe context in which it usually occurs:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Frequency: ______________________________________ Has your child every gone missing? ☐Yes ☐No

If yes, how long were they missing? _________________ Were police involved? ______________________________
Consequences Used:

_______________________________________________________________________________________________

_____________________________________________________________________________________________

Self-Stimulatory Behavior: ☐Yes ☐No
Describe context in which it usually occurs:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Frequency: ______________________________________ Duration: ___________________________________

Consequences Used:

_______________________________________________________________________________________________

_____________________________________________________________________________________________

Other Behaviors:

Description:

_______________________________________________________________________________

_______________________________________________________________________________

Frequency: ________________________________ Duration: ________________________________

Consequences Used:

_______________________________________________________________________________

_______________________________________________________________________________

Self-Stimulatory Behaviors – Other Information (Describe if you child demonstrates any of the following)

Unusual attachments to objects:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Repeats previously heard words out of context (echolalia):

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Verbalizing in a repetitive manner (i.e. eee sounds, babbling, screaming, etc.):

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Difficulty with transitions or changes in routine:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Unusual interest in the sight, feel, sound, or smell of things:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Unusual preoccupations/obsessions (anything he/she likes to do repeatedly):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Social Behavior

Does your child show you affection? How?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How does your child play with other children?

______________________________________________________________________________

______________________________________________________________________________

How does your child play with toys?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list your child's favorite toys, activities, music, food, games, etc,:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child give eye contact? ☐Yes ☐No

Under what circumstances is the eye contact given?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child respond to his/her name? ☐Yes ☐No

Does your child come to you for comfort? ☐Yes ☐No

Does your child greet you in anyway when he/she sees you? ☐Yes ☐No How?
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child show interest in other people? ☐Yes ☐No Y N
Please indicate whom and how your child shows interest in other people:
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child attempt to involve you in something he/she is doing? ☐Yes ☐No
Please describe some examples:
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child get involved with something you are doing? ☐Yes ☐No
Please describe some examples:
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child respond better to any particular person? ☐Yes ☐No

To whom? ______________________________________________________________________

Why do you think that is? _______________________________________________________

General Language
Did your child have speech that he/she lost? ☐Yes ☐No If yes, at what age did he/she start to lose speech? ______

What is your child's usual way of communicating?
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child cry to let you know if he/she wants something? ☐Yes ☐No
Does your child take you or point to what he/she wants? ☐Yes ☐No
Does your child say what he/she wants? ☐Yes ☐No

Receptive Language
Does your child follow verbal instructions without visual cues? ☐Yes ☐No
How much do you think your child understands?
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Expressive Language
Does your child have any words? If yes, please give examples:
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Are the words your child has used in context or out of context?
______________________________________________________________________________

______________________________________________________________________________

Does your child babble or combine sound so that the combined sounds resemble some speech?
______________________________________________________________________________

______________________________________________________________________________

Are there any words that your child imitates? If yes, please list the words:
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What is the average length of your child's utterances (words)?
______________________________________________________________________________

______________________________________________________________________________

Are there problems with your child's articulation or intonation of speech?
______________________________________________________________________________

______________________________________________________________________________

Can your child hold a conversation about a favorite topic? ☐Yes ☐No
If yes, please describe:
______________________________________________________________________________

______________________________________________________________________________

Please list any additional comments you would like to make regarding your child's speech and language:
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Educational Background**

Does your child attend school? ☐Yes ☐No

What is the name of the school? ______________________________ How long attended? ___________

What type of program does your child attend?
______________________________________________________________________________

______________________________________________________________________________

How long has your child been attending school? _________________________________

Does your child have aide/para while at school? ☐Yes ☐No If yes, para with your child full or part time? _______

Is there current IEP? (If so, please provide copy) ☐Yes ☐No

Are you satisfied with the school program? ☐Yes ☐No

Explain:
______________________________________________________________________________

______________________________________________________________________________

Please list your child's current and past services:

Service 1:

Type of Treatment: ___________________________________________________________

Service Provider: ____________________________________________________________

Duration of Treatment: _______________________________________________________

Child's Response to Treatment: _________________________________________________

Service 2:

Type of Treatment: ___________________________________________________________

Service Provider: ____________________________________________________________

Duration of Treatment: _______________________________________________________

Child's Response to Treatment: ____________________________________________

Service 3:
Type of Treatment: ____________________________________________

Service Provider: ____________________________________________

Duration of Treatment: ____________________________________________

Child's Response to Treatment: ____________________________________________

Service 4:
Type of Treatment: ____________________________________________

Service Provider: ____________________________________________

Duration of Treatment: ____________________________________________

Child's Response to Treatment: ____________________________________________

Is your child seeing any other behavioral health clinicians? (psychiatrist, social worker, psychologist)

____________________________________________

Reason for seeking our Services - What are your goals and expectations from us?

____________________________________________

____________________________________________

____________________________________________

Goals and Objectives:
Please list some goals that you would like your son/daughter to achieve:
Reason for Seeking Services - What are your goals and expectations from us?

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Is there other additional information you would like us to know about your child/family?

____________________________________________

____________________________________________

______________________________________________________________________________

______________________________________________________________________________

Do you currently have any relevant legal issues? (example: taking action against your school system, etc)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Other relevant information:
Is the client up-to-date on the CDC Immunization Schedule? ☐Yes ☐No
If No, Please Describe:

______________________________________________________________________________

______________________________________________________________________________

To your knowledge, has the client tried any of the following?

Tobacco ☐ Yes ☐No
Alcohol ☐ Yes ☐No
Street or Recreational Drugs ☐Yes ☐No
Over the counter drugs ☐Yes ☐No

What does the client and family do for fun?

☐Games
☐Outings
☐Movies
☐Other: ______________________________________________________________________
☐Sports
☐Other Functions

What do you feel are your child's strengths?

☐Academics
☐Art
☐Helpful
☐Plays well with others
☐Other: ______________________________________________________________________
☐Music
☐Sports
☐Good Natured
☐Cooperative

What is a list of your child's favorite activities?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your family utilize any community resources (e.g. support groups, social services, school based services, other social supports)? ☐Yes ☐No

Please Describe: _______________________________________________________________

______________________________________________________________________________

**Emergency Contact Information**

Individual's Name ________________________________DOB________________________

In case of an emergency, please contact the following people in the order listed (after the parent/guardians):

Name: ___________________________________Relationship: _______________________

Phone Number(s): ____________________________________________________________

Name: ___________________________________Relationship: ________________________

Phone Number(s): ____________________________________________________________

Name: ___________________________________Relationship: ________________________

Phone Number(s): ____________________________________________________________

Other than emergencies as identified by Aspire Behavioral Solutions, I would like to be contacted in the following situations__________________________________________________________________________________

___________________________________________________________________________________________

**Information Release Form**

**Effective Date: __________________to __________________**
**Release for Information from: __________________to __________________**

Patient Name: Patient DOB: Caregiver:

☐ Individual Education Plan (IEP) / 504 Plan
☐ School progress reports
☐ Other school reports
☐ Diagnostic Reports/Evaluations
☐ Treatment Assessments and Reports from previous or current providers
☐ Treatment data records from previous or current providers
☐ Treatment programs from previous or current providers
☐ Other: ____________________

Information may be shared in an effort to provide or otherwise coordinate services with the following:

| | Address | Phone | Fax |
|---|---|---|---|
| Previous ABA Providers | | | |
| | | | |
| | | | |
| Current or Previous Therapies | | | |
| | | | |
| | | | |
| | | | |
| School/Preschool Providers | | | |
| | | | |
| | | | |
| Primary Care Physician | | | |
| | | | |
| Diagnostician's Office | | | |
| | | | |
| Other | | | |
| | | | |

I authorize this release of information and understand I may discontinue the release at any time by submitting the desire to do so in writing to Aspire Behavioral Solutions.

________________________________ ________________________________ __________

Caregiver/Guardian Name Caregiver/Guardian Signature Date

**Media Release Authorization**

I, the undersigned, do hereby consent and agree that Aspire Behavioral Solutions, LLC (ABS), its employees, or agents have the right to take the following:

☐ Photographs
☐ Videotape
☐ Digital recordings

I authorize ABS to use the above media forms to record the following:

☐
☐ My child during ABS events
☐ My child during sessions
☐ My child's work
☐ Me or my family during ABS events
☐ Me or my family during sessions/parent/sibling trainings

I consent for Aspire Behavioral Solutions, LLC (ABS) to use these in any and all media, now or hereafter known, and exclusively for the purpose of marketing, advertisement, and social media networking. I further consent that my identity may be revealed therein or by descriptive text or commentary. Other than images, no identifying information for my child or me will ever be used without my separate, written consent.

I do hereby release to Aspire Behavioral Solutions, LLC (ABS), its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately. I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

☐ I do NOT consent to any media forms of me or my child

I represent that I am at least 18 years of age, have read and understand the foregoing statement, am competent to execute this agreement, and am the legal guardian of the child listed.

| | |
|---|---|
| ______________________________ | ______________________________ |
| (Child's Name) | (Guardian Printed Name) |
| ______________________________ | ______________________________ |
| (Guardian Signature) | (Date) |