AUTISM BEHAVIOR SUPPORT
4003 W Stan Schlueter Loop Suite 3, Killeen, TX 76549
(254) 630-1578
Fax: (254) 267-1091
autismbs6@gmail.com

Client Registration Form

Client Information:

Client Name: _____ DOB_____ Age_____

Address: _____

Social Security No.: _____ Gender: M F

Parent/Guardian Information:

Mother's Name: _____

Address: _____

Date of Birth: _____ Social Security No.: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Insurance Carrier: _____

Father's Name: _____

Address: _____

Date of Birth: _____ Social Security No.: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Insurance Carrier: _____

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Siblings/Household Members (Other than parent/guardian):

Name: _____

Date of Birth: _____Relationship: _____

Name: _____

Date of Birth: _____ Relationship: _____

Name: _____

Date of Birth: _____Relationship: _____

Name: _____

Date of Birth: _____Relationship: _____

Emergency Contact Information:

Name: _____

Phone Number: _____ Relationship to Child: _____

Name: _____ Phone Number: _____

Relationship to Child: _____

Other Services Provided (Speech/PT/OT, etc.):

Name of Provider: _____

Services Provided/Times per week: _____

Name of Provider: _____

Services Provided/Times per week: _____

Name of Provider: _____

Services Provided/Times per week: _____

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Diagnosis:

Primary Diagnosis 1: _____

Diagnosis Date(s): _____

Diagnosing Professional: _____

Primary Diagnosis 2:_____

Diagnosis Date(s): _____

Diagnosing Professional: _____

Primary Diagnosis 3: _____

Diagnosis Date(s): _____

Diagnosing Professional: _____

Medical Conditions (if any): _____

_____

Allergies: _____

Diagnosing Professional: _____

Special Diet Information: _____

Current Medications;

1.

2.

3.

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Child's Educational Background:

School: _____ Grade: _____ _____

Home School _____ General Education _____IEP_____ 504_____

Please list any other important information you would like us to know about your child.
_____
_____
_____
_____

Informed Consent

Client Name: _____ DOB: _____

I, _____, agree to have my child _____ evaluated/treated through ABA Therapy Solutions, LLC. I understand that these services are based on an applied behavior analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse. I also understand that ABA Therapy Solutions, LLC specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if ABA Therapy Solutions, LLC is unable to meet my particular needs, I will be referred to an appropriate agency or individual. Services: ABA Therapy Solutions, LLC implements the Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made, if needed. When a client is a minor under the age of 14, parent involvement is required during all visits with the Client. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.