

Applied Behavioral Learning Services ABLS

Application for Behavioral Services

Child's Name: _____ Date of Birth: _____

Diagnosis: _____ Evaluator who made diagnosis: _____ Date: _____

Mother's Name: _____ Father's Name: _____

Mother's Education: _____ Father's Education: _____

Mother's Occupation: _____ Father's Occupation: _____

Home Address: _____

Contact Information: home phone: _____ work: _____

email: _____ mobile: _____

Siblings/Ages: _____

Caretakers: _____

Other people living in the home: _____

What language is spoken in the home? _____

Referred to the Integrated Center for Child Development (ICCD) by: _____

Chief Problem or concern: _____

What do you hope to gain from this consultation? _____

Current School Placement

Present Grade: _____ Has your child repeated a grade? _____

Name of School: _____

School Address: _____

School Contact Person: _____

Teacher: _____ Phone Number: _____

Teacher assistant or one-to-aide: _____

ABA (Applied Behavior Analysis) Instructor or Behavior Therapist: _____

Behavior Analyst or Specialist: _____

Number of hours of ABA per week: _____ Number of hours of consultation per week: _____

Occupational Therapy Services (per week): _____

Physical Therapy Services (per week): _____

Speech Language Services (per week): _____

On an average school day how much time does your child spend:

- Doing homework (if applicable)? _____ Alone? _____ With your help? _____
- Socializing with peers? _____ With family members? _____ With other adults? _____
- Watching TV? _____ Using computer (non-academic)? _____
- Reading for pleasure (or being read to)? _____

Has your child been evaluated under Chapter 766 (Core Evaluation)? _____

If yes, please include a copy of all Individualized Educational Programs (proposed and/or accepted).

Has an independent evaluation been conducted? _____

Evaluator: _____ Date of Evaluation: _____

If yes, please include a copy of the assessment.

Communication

How does your child communicate? _____

Play Skills

How does your child play? _____

Daily Routine

Please describe your child's regular schedule (including naps):

	Mon	Tues	Wed	Thu	Fri	Sat	Sun
7:00-8:00 am							
8:00-9:00							
9:00-10:00							
10:00-11:00							
11:00-12:00 pm							
12:00-1:00							
1:00-2:00							
2:00-3:00							
3:00-4:00							
4:00-5:00							
5:00-6:00							
6:00-7:00							
7:00-8:00							

Self Help Skills

Eating: _____

Dressing: _____

Bathing: _____

Toileting: _____

Behavior

Aggression: _____

Stereotypy (any repetitive movement without apparent purpose): _____

Self Injurious Behavior: _____

Other Maladaptive Behavior: _____

Has your child ever received psychotherapy or counseling? _____

If yes, why? _____

Have you ever worked with a behavioral consultant? _____

If yes, please give the name(s) of the consultants: _____

Please describe the child's strengths: _____

Please describe the child's weaknesses: _____

Is your child on any medication? (Please list): _____

Developmental History

Pregnancy: _____

Infancy: _____

Feeding Problems? _____

Sleeping Problems? _____

Developmental Milestones

Sat at age: _____ Walked at age: _____

Smiled at age: _____ Spoke in two-word phrases at age: _____

Family History

Please list family members/relatives with academic problems (e.g. reading, mathematics, spelling, etc.) and the types of problems:

Please list family members/relatives with behavioral problems (e.g. overactive, withdrawn, trouble with the law, aggressive behavior, etc.):

Please list family members/relatives with psychiatric problems (e.g. depression, schizophrenia, etc.)

Please list family members/relatives with neurological problems (e.g. seizures, mental retardation, etc.)

Child's Health

Please describe the child's general health: _____

Please describe the parent's general health: _____

Does your child have any specific medical problems? _____

Serious Illness? _____

History of seizures/convulsions? _____

Operations? _____

Other Hospitalizations? _____

Allergies? _____

Sensitivities? _____

Ear Infections? _____

Visual Problems? _____

Diet Restrictions? _____

Signature

Date

Please feel free to note any other concerns below:

