CLIENT INTAKE

Date of Intake:

Intake Completed by:

Basics

Name:	**Marital Status:**
Gender:	**DOB:**
Address:	
Phone:	**Email:**
Parent/Caregiver Names:	

Claims Settings

Diagnosis (ICD-10 Code):

Diagnosing Physician's Name and Practice Name:

Date of Initial Diagnosis:

Physician's Name who Completed the Most Recent Evaluation:

Date of Most Recent Evaluation:

Payors- Insurance

Insurance Name:	**Coverage start date:**
Subscriber Name:	**Subscriber DOB:**
Subscriber SSN:	**Subscriber Gender:**
Group #:	**Member ID #:**
Subscriber Address:	
Patient's Relationship to Subscriber:	

ABASFR will need a photo of the front and back of the card for your file.

Payors- CES/CWA Waiver

Medicaid #:	**Case Manager Name:**

Case Management Company:

Case Manager Phone: **Case Manager Email:**

ABASFR will need a photo of the front and back of the card for your file.

Health Record-Allergies

Type: Drug/Food/Environment

Allergy:

Severity: **First Observed:**

Notes:

Type: Drug/Food/Environment

Allergy:

Severity: **First Observed:**

Notes:

Type: Drug/Food/Environment

Allergy:

Severity: **First Observed:**

Notes:

Health Record- Current Medications

Medication Name: **Start date:**

Strength: **Dosage:**

How taken: **How often:**

Reason taking:

Medication Name: **Start date:**

Strength: **Dosage:**

How taken: **How often:**

Reason taking:

Medication Name: **Start date:**

Strength: **Dosage:**

How taken: **How often:**

Reason taking:

Scheduling

Availability:

Unavailability:

Number of Sessions per week: **Length of session:**

Behavior Reduction

Describe any behaviors of concern and how often they occur:

Skill Acquisition

Describe skill areas you would like to address through ABA services: