ABORDER
BEHAVIORAL HEALTH

Service Inquiry			
Client Name:			
Age:		**DOB:**	
Diagnosis			
Did your child previously receive ABA?		Yes ☐ No ☐	
If yes, provide the range of dates and the names of the providers:			
What services are you interested in? (please circle one from the list below)			
☐ orning Therapy Sessions | ☐ lid-Day Therapy Sessions | ☐ eschool Sessions ☐ fternoon Sessions			
How would you describe your child's verbal abilities? (please check one from the list below)			
☐ 1. Non-verbal (does not use words or signs to express any wants or needs) ☐ 2. Verbal (uses some words or signs to express wants or needs) ☐ 3. High-verbal (uses sentences to communicate and engages in conversation)			
How would you describe your child's problem behavior? (please check one from the list below)			
☐ 1. Compliant (does not engage in any concerning behaviors) ☐ 2. Mild/Moderate (engages in some problem behavior, such as crying, whining, tantrums) ☐ 3. Severe (engages in high frequency of concerning behavior, such as hitting, biting, destruction)			
Guardian Name:		**Relationship:**	
Contact Number:			
Contact Email:			
Home Address:			

Primary Insurance Coverage		Secondary Insurance Coverage	
Policy Holder:		Policy Holder:	
Insurance Carrier:		Insurance Carrier:	
Insurance Policy No:		Insurance Policy No:	
Insurance Group No		Insurance Group No:	

Availability for Services

Please indicate your child's availability for therapy:

***Please note: Slots in the afternoons are primarily reserve for children over the age of 5.**

Days of the week	Day Time Shifts	Afternoon Shifts
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Comment:		

Clinical Documentation Checklist:

- ☐ Primary Care Referral
- ☐ Clinical Diagnostic Evaluation
- ☐ IEP Documents
- ☐ Speech Evaluation
- ☐ Occupation Evaluation

Email the completed Service Inquiry Form to:

☐ **info@aborderhealth.com**