9038 Cross Park Drive, Suite 105
Knoxville, TN 37923
Phone: 865-394-6612 Fax: 865-315-7014

Enrollment Application

Please Check: ___ Knoxville Center __ Morristown In-Home Therapy

Please complete the following form fully. Once information is received, we will contact you to set up an evaluation. Incomplete applications will not be reviewed.

Child Information

Child's Name		**Date of Birth**	
Street Address		**Age**	
City, State, Zip		**Sex**	**M F**

Primary Diagnosis		**Age of Diagnosis**	
Diagnosing Physician			
Other Diagnoses			
Referring Physician for ABA Assessment/ Treatment			
Does your child have a current psychological evaluation?		**Yes**	**No**
Completed by			
Date of last psychological evaluation			

Insurance Information

Plan		**Insured's Name**	
ID Number		**Insured's Date of Birth**	
Group Number		**Relationship to Client**	

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ID Number		**Insured's Date of Birth**	
Group Number		**Relationship to Client**	

Family Information

	Mother	Father
Name		
Address		
Phone		
Email		
Custody	Full Joint None	Full Joint None
Who lives in the primary home?		
Primary language spoken at home		

Medical Information

Does your child:	**Yes**	**No**	**If yes, please list:**
Take medication?			
Have medical conditions?			
Have allergies?			
Follow a special diet?			
Does your child:	**Yes**	**No**	**If yes, please list provider:**
Receive speech services?			
Receive OT services?			
Receive PT services?			
Other services?			

Developmental Information

Does your child:	**Yes**	**No**	**If yes, please explain:**
Have feeding concerns?			
Need help with dressing?			
Need help with bathing or other self-care tasks?			
Is your child toilet trained?			

Speech, Language and Hearing

Does your child:	Yes	No	If yes, please describe:
Have a speech delay?			
Have a hearing deficit?			
Use a picture exchange system or assistive communication device?			

How does your child typically communicate?	Grunts, screams, whines	Points / gestures / eye contact	Pulls / leads others	Uses 1-2 words	Speaks in sentences
To get your attention					
To request something					
To refuse / protest					
To greet others					

Does your child:	Yes	No	Comments
Imitate others?			
Follow simple directions most of the time?			
Respond correctly to yes/no questions?			
Respond correctly to simple questions?			
Participate in back and forth conversations?			
Play with age-appropriate toys?			
Show interest in other children?			

School History

Does your child:	Yes	No	Comments
Attend school?			Part-time Full-time Home-schooled Total hours in school:
Participate in a general education classroom?			Number of hours:
Participate in a special education classroom?			Number of hours:
Have an IEP or 504 plan?			If yes, please attach a copy.

Challenging Behaviors

Is this behavior a concern?	Yes	No	If yes, please describe:
Elopement (running)			
Tantrums			
Property damage			
Self-injury			
Physical aggression			
Verbal aggression			
Repetitive behaviors			
Other:			

Preferences (please list)

Preferred Items	
Preferred Activities	
Preferred People	
Preferred Foods	

Goals of ABA Therapy – Choose 3

Please select your top 3 goals you would like your child to achieve through ABA therapy:

	Improve ability to communicate wants and needs
	Improve social skills with peers
	Improve cooperation with requests from others
	Increase self-care skills (bathing, toileting, tooth-brushing, etc)
	Improve focus and task completion
	Improve toleration of changes
	Improve play skills
	Increase school-readiness skills
	Improve behavior during transitions
	Toilet-training
	Decrease meltdowns/tantrum behavior
	Decrease repetitive behaviors
	Decrease elopement
	Decrease self-injurious behavior
	Decrease aggressive behavior
	Decrease food selectivity/refusal
	Other:

Active Participation in Services

Are you willing to:	**Yes**	**No**
Ensure your child's attendance at multiple weekly ABA sessions?		
Attend parent trainings weekly?		
Implement treatment plan to the best of your ability?		
Make environmental modifications at home as recommended?		

Availability for Services

Please indicate ALL of the following schedules for which your child is available for therapy:

Days	9am to 12pm	12pm to 2pm	2pm to 5pm
Mon / Wed / Fri			
Tues / Thurs			
Comments:			

Potential Barriers	Yes	No	Please provide details (e.g., days/times affected)
Does your child attend other therapies?			
Are you willing to re-schedule other therapies if needed to fit your child's ABA schedule?			
Does your child attend school/ pre-school?			
Are you willing to do school pull-out if recommended?			
Will caregiver work schedule or transportation be a barrier to bringing your child to therapy?			
Are there other barriers that may affect your child's availability?			

I acknowledge that all information contained in this application is accurate.

_____ _____

Parent Signature **Date**

_____ _____

Reviewer Signature **Date**

*** Please attach to this enrollment form a referral, IEP or 504, and/or Psychological Evaluation. If a custody order is in place, attach a copy.**