Aligned
CLINICAL & EDUCATIONAL SERVICES, PLC

Aligned Clinical & Educational Services (ACES), PLC
MAILING ADDRESS: P.O. Box 28, Crozet, VA 22932
OFFICE ADDRESS: 325 Four Leaf Lane, Suite 12, Charlottesville, VA 22903
PHONE: (434) 466-1588 VP: (434) 326-1496 FAX: (434) 823-1174

Welcome to ACES Applied Behavior Analysis Services!

In order for us to get to know the needs of our clients and client families, we ask that you fill out the following intake form as thoroughly as you can.

Before our first meeting we will need the following paperwork in addition to the ACES intake forms:

- ❑ Letter of medical necessity, if required by funding source
- ❑ Recent educational/psychological evaluations or diagnostic reports (from within the past two years)
- ❑ A completed behavioral intake form
- ❑ Most recent IEP/ISP/IFSP/ or 504 plan
- ❑ Most recent Behavior Intervention Plan
- ❑ Progress or discharge reports from current/previous provider(s)

Logistics

What type of ABA program are you interested in:

Comprehensive (addressing skill acquisition and behavior reduction)	☐	Focus on activities of daily living	☐
Early intervention / Early learning	☐	Focus on coping/emotional regulation	☐
Focus on behavior reduction	☐	Focus on social skills	☐
Focus on skill acquisition	☐	Parent or Caregiver training	☐

What is the maximum hours per week you wish to receive services?

- ❑ 1-2
- ❑ 2-4
- ❑ 5-7
- ❑ 8-10

What is the minimum hours per week you wish to receive services?

- ❑ 1-2
- ❑ 2-4
- ❑ 5-7
- ❑ 8-10

Where do you wish to receive services?

☐ In-home ☐ In-office ☐ Community-based

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Profile

Date:

Client name: Client date of birth:

Client Gender: M ☐ F ☐ Client Current Age:

Form completed by: Relationship to client:

Home Language: Spoken or Signed?

Caregivers/relatives with regular contact with client

Primary caregiver name: Relationship to client:

Address:

Home phone: Cell phone:

Email: Lives with client? ☐ No ☐ Full-time ☐ Shared-time

Caregiver name: Relationship to client:

Address:

Home phone: Cell phone:

Email: Lives with client? ☐ No ☐ Full-time ☐ Shared-time

Caregiver name: Relationship to client:

Address:

Home phone: Cell phone:

Email: Lives with client? ☐ No ☐ Full-time ☐ Shared-time

Who else lives in the home or has regular contact with the client?

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Medical Information

Primary diagnosis: Date of diagnosis:

Who gave diagnosis:

Please list all other diagnoses (developmental, psychiatric, medical):

Current medications

Name	Dosage	Purpose

Allergies:

Diet restrictions/preferences:

Does the client have any of the following:

Seizures ☐ Wheelchair ☐ Walker ☐ Visual impairment ☐

Hearing loss ☐ Hearing aids ☐ Cochlear implant ☐ Other:

Does the client currently attend school, daycare, or a day treatment program? ☐ Yes ☐ No

Is there an active IEP? ☐ Yes ☐ No

School/program name: Contact name:

Address:

Contact number: Contact email:

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Please list all current and past clinical services (SLP/OT/PT etc.)

Name of Service	Provider	Hours per week	Current / Past
			☐ Current ☐ Past
			☐ Current ☐ Past
			☐ Current ☐ Past
			☐ Current ☐ Past
			☐ Current ☐ Past

Past and current alternative therapy / intervention

	Past	Current		Past	Current
Gluten/Casein Free Diet	❑	❑	Son-Rise	❑	❑
Sensory integration	❑	❑	Rapid Prompting Method	❑	❑
Floortime	❑	❑	Hyperbaric Chamber Treatment	❑	❑
Chelation	❑	❑	Other:	❑	❑

Activities of Daily Living

Does the client feed him/herself independently? ☐ Yes ☐ No

Does the client drink from a bottle or sippy cup? ☐ Yes ☐ No

Is the client toilet trained? ☐ Yes ☐ No

Describe eating and drinking patterns and issues of concern:

Describe sleeping patterns and issues of concern:

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Describe toileting patterns and issues of concern:

Describe independent dressing skills and issues of concern:

Behaviors of Concern

Does the client engage in any of the following behaviors?

	Yes	No		Yes	No
Physical aggression	☐	☐	Repetitive behaviors / stereotypy	☐	☐
Property destruction	☐	☐	Verbal outbursts	☐	☐
Eloping (running away)	☐	☐	Self injurious behavior	☐	☐
Tantrums	☐	☐	Self stimulatory behavior	☐	☐

What are the top 3 behaviors you hope to address?

Behavior 1:

Description:

Examples:

How often does the behavior occur? (100x a day? 10x a week?)

Settings in which the behavior occurs (home / school /community):

When is the behavior likely to occur?

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How do people (staff, parents, etc.) typically respond to this problem behavior?

Which of the following procedures have been used to address the problem behavior?:

Restraint: ☐ Yes ☐ No	Describe:
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Protective Equipment (e.g., helmet, gloves): ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Positive reinforcement procedures: ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Time out: ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Behavior 2:

Description:

Examples:

How often does the behavior occur? (100x a day? 10x a week?)

Settings in which the behavior occurs (home / school /community):

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When is the behavior likely to occur?

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Which of the following procedures have been used to address the problem behavior?:

Restraint: ☐ Yes ☐ No	Describe:
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Protective Equipment (e.g., helmet, gloves): ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Positive reinforcement procedures: ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Time out: ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Behavior 3:

Description:

Examples:

How often does the behavior occur? (100x a day? 10x a week?)

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Settings in which the behavior occurs (home / school /community):

When is the behavior likely to occur?

How do people (staff, parents, etc.) typically respond to this problem behavior?

Which of the following procedures have been used to address the problem behavior?:

Restraint: ☐ Yes ☐ No	Describe:
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Protective Equipment (e.g., helmet, gloves): ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Positive reinforcement procedures: ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Time out: ☐ Yes ☐ No	Describe
Still used?: ☐ Yes ☐ No	Success: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

What level of supervision is required?

☐ Constant supervision by two adults 2:1 ☐ Constant supervision by one adult 1:1

☐ Small group ☐ Large group ☐ Completely independent

Can be left alone for brief periods: ☐ Yes ☐ No

Needs constant monitoring, but can work in a group: ☐ Yes ☐ No

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Communication Skills

Skill	Consistently	Sometimes	Never
Speaks/Signs freely and easily			
Speaks/Signs mainly in phrases			
Uses single words/signs			
Uses modified signs (not Deaf/HOH)			
Uses gestures			
Communicates with pictures			
Understands simple questions			
Follows simple instructions			
Verbally imitates			
Physically imitates			

Name of communication device used (if applicable):

Skill Acquisition:

What are the top 3 skills you would like the client to learn?

Skill 1:

Description:

Examples:

Skill 2:

Description:

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Examples

Skill 3:

Description:

Examples:

Additional Skills:

Preferences

What items, activities, places, or environments does the client prefer?

Social interaction	☐ With caregivers ☐ With peers ☐ With adults?
Types of social interaction	(examples include praise, fist bump, hugs, etc.)
Favorite food	
Favorite toys	
Favorite activities	
Physical activities	
Other	

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Aversions

What items, activities, places, or environments does the client not like?

Expectations/Narrative

Describe your goals for the client: