



ABA Today



ABA4Autism



ABA New England



Gateway4ABA

Patient Intake Form

This fillable form may be used for ABA New England, ABA4Autism, ABA Today, or Gateway4ABA. Complete the applicable company selection and signature sections contained in the form.

Before completing this form

Open the PDF in a compatible viewer to enter information and save your responses.



ABA Today



ABA4Autism



ABA New England



Gateway4ABA

HEREAFTER: "The Companies"

NOTE: This form can be used for one or more of the listed companies. See the signature page for the applicable company(ies).

Patient Intake Form

Please complete all sections as thoroughly as possible. This form collects information required to determine eligibility for services, design clinically appropriate treatment, and comply with HIPAA and payer requirements. Please contact The Companies for questions.

01. Patient Information			
Patient Full Legal Name			
Preferred Name/Nickname			
Date of Birth (MM/DD/YYYY) & Age			
Sex at Birth	☐ Male ☐ Female ☐ Intersex ☐ Prefer Not To Say		
Gender Identity (Optional)			
Primary Language(s)			
Race/Ethnicity (Optional)			
Address Line 1 Address Line 2			
City, State, ZIP			
School/Program Name <i>If Applicable</i>			
Grade/Classroom Type <i>If Applicable</i>			

02. Parent / Legal Guardian Information	
Guardian #1	
Name	
Relationship to Patient	

Phone			
Email			
Address Line 1 Address Line 2			
City, State, ZIP			
Guardian #2			
Name			
Relationship to Patient			
Phone			
Email			
Address Line 1 Address Line 2			
City, State, ZIP			
Legal Custody Status	☐ Joint ☐ Sole ☐ Other (Explain):		

03. Emergency Contacts <i>Other than guardians (required)</i>	
Emergency Contact #1	
Name	
Relationship	
Phone	
Alternate Phone	

Emergency Contact #2	
Name	
Relationship	
Phone	
Alternate Phone	

04. Insurance & Financial Information	
Primary Insurance Carrier	
Plan Type	☐ Commercial ☐ Medicaid ☐ Tricare ☐ Self-Pay
Member ID	
Group Number	
Subscriber Name & DOB	
Subscriber Relationship to Patient	
Secondary Insurance Carrier <i>If Applicable</i>	
Member ID	
Authorization Required?	☐ Yes ☐ No ☐ Unknown

05. Referring Provider / Diagnosis	
Referring Physician / Provider	
Practice Name	
Phone / Fax	
Primary Diagnosis	
Date of Diagnosis	
Diagnostic Provider	

06. Medical History	
<i>Please check all that apply and provide details where relevant</i>	☐ Autism Spectrum Disorder ☐ ADHD ☐ Intellectual Disability ☐ Speech/Language Disorder

	☐ Genetic Condition (<i>specify</i>):	
	☐ Seizure Disorder (<i>last seizure</i>):	
	☐ Allergies (<i>food/medication/environmental</i>):	
	☐ Medications (<i>name/dose/frequency</i>):	
	☐ Sleep Difficulties	
	☐ Feeding/Eating Concerns	
	☐ Sensory Sensitivities	
	☐ Other Medical Conditions	
Primary Care Physician Name & Phone		

07. Developmental History	
Pregnancy/Birth Complications	
Developmental Milestones <i>Delays/Regressions</i>	
Age First Concerns Were Noted	
Previous Evaluations <i>Psychological, Medical, Educational</i>	

08. Educational & Therapy History	
Current School/Program	
IEP/504 Plan? <i>Attach if available</i>	☐ Yes ☐ No
Current Services	☐ ABA ☐ Speech ☐ OT

	☐ PT ☐ Counseling ☐ Other:
Past Services <i>Type/Dates</i>	
Reason for Discharge From Prior ABA <i>If Applicable</i>	

09. Behavioral & Functional Concerns <i>Describe current concerns & strengths</i>	
Primary Behavioral Concerns	
Triggers/Antecedents	
Safety Concerns <i>Elopement, Aggression, Self-Injury</i>	
Communication Skills ☐ Verbal ☐ AAC ☐ Gestures ☐ Limited	
Daily Living Skills	
Strengths/Interests/Motivators	

10. Family Goals & Priorities <i>What are your top goals for your child and family?</i>	
1.	
2.	

3.	

11. Availability & Service Preferences	
Preferred Service Setting	☐ Center ☐ School ☐ Hybrid
Days/Times Available	
Preferred Start Date	

12. Consent to Release & Exchange Information (HIPAA)

I authorize The Companies to use and disclose protected health information (PHI) as necessary for treatment, payment, and healthcare operations, including communication with insurer, physicians, school, and other service providers involved in my child's care, consistent with HIPAA regulations.

☐ Yes
☐ No *If no, limitations:*

13. Acknowledgements

- I certify that the information provided is accurate and complete to the best of my knowledge
- I understand that incomplete or inaccurate information may delay services.
- I acknowledge receipt of the Notice of Privacy Practices (separate document).

See Signature Page Below



ABA Today
EIN: 83-1284899



ABA4Autism
EIN: 46-2924423



ABA New England
EIN: 88-3984639



Gateway4ABA
EIN: 86-2549483

INSTRUCTIONS:

Signatory should sign under the banner(s) of the relevant company(ies) from which they are receiving services or employment.

ABA Today

Signatory Printed Name

Manager Printed Name

Signatory Signature

Manager Signature

Date Signed

Date Signed

ABA4Autism

Signatory Printed Name

Manager Printed Name

Signatory Signature

Manager Signature

Date Signed

Date Signed

ABA New England

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Manager Printed Name

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