Bright Futures Learning Services

Basic Information

Today's date: _____

Child's Name: _____ Gender: M F Birthdate: _____

Address: _____ City: _____ State: ____ Zip _____

Parent(s)/Guardian(s):

Name Relationship Day Evening
(1)_____ to child:_____ Phone:_____ Phone: _____

Email address:_____ Cell Phone:_____

Employer: _____

Name Relationship Day Evening
(2)_____ to child:_____ Phone:_____ Phone: _____

Email address:_____ Cell Phone:_____

Employer: _____

Emergency Contact: (Other than parent/guardian):

Name Relationship Day Evening
_____ to child:_____ Phone:_____ Phone: _____

Cell Phone:_____

Siblings

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____

Other Family Members (those who are particularly familiar to your child)

Name Child Uses/Knows	Relationship	Name Child Uses/Knows	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

Pets

_____	_____	_____	_____

Educational History (If your child has an IEP, 504 plan, or an IPP, please enclose a copy of the plan)

School Name	Dates	City/State	County
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child have a home ABA program?

Agency/Consultant	Hours per Week	Dates of Program

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Medical Information

Child's Primary Physician

Name	Phone	Address/City

Has a Physician or Psychologist Prescribed Applied Behavior Analysis for Your Child? Yes No

Name	Phone	Address/City

Child's Health Problems

Diagnosis	Comments	Diagnosis	Comments

Medications

Medication	Daily Dosage	Taken For	Medication	Daily Dosage	Taken For

Current Treatments and Therapies

Provider Name	Type of Therapy	How Much?	How Often?	Where?

Allergies

Special Diet or Food Sensitivity/Intolerance

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Getting Started!

Please share with us your observations about your child. The more detail the better! The information you share will help us plan appropriately and get off to a good start.
Thank You!

Child's Name: _____ Today's Date: _____

1. List your child's five favorite things or activities.

2. List three things at which your child is particularly good.

3. Describe some tasks that are particularly difficult for your child or things he or she dislikes doing.

4. What are your greatest concerns about your child's behavior and development at this time?

5. What behaviors does your child exhibit when asked to do things he or she does not enjoy?

6. Does your child exhibit aggressive behaviors? If so, when are they most likely to occur?

7. List any "self-stimulatory" behaviors (e.g. hand flapping, rocking, gazing at objects, repetitive vocal sounds) in which your child engages and note how frequently they occur.

8. List therapies/treatment programs in which your child has participated in the past (you do not need to repeat the ones listed on the medical information sheet).

9. Describe your child's sleeping habits such as sleeping patterns at night, length of time at night and any napping during the day (you can use the schedule in this packet to mark approximate times).

10. Please describe any special diet your child requires and/or drug therapy program in which your child participates.

12. Are you and any of your family members familiar with Applied Behavior Analysis methodology? If so, to what degree are you able or want to participate in the program?

14. List any ABA or autism-related books you have read and any workshops or conferences you have attended. Describe any other sources of information that have been available to you.

15. Do you know any other families currently engaged in an ABA program for their child? If so, do you know how long have they participated in this ABA program?

17. In the next month I would be very happy if my child could…

18. In the next six months I would be very happy if my child could…

19. In the next year I would be very happy if my child could…

20. Other things I want you to know about my child…

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Week at a Glance

What does your child's current schedule look like? In a **very general** way, show us what your child is used to – sleep/wake patterns, mealtimes, play, family time, community activities, school/daycare/therapy, etc.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6 am							
7 am							
8 am							
9 am							
10 am							
11 am							
noon							
1 pm							
2 pm							
3 pm							
4 pm							
5 pm							
6 pm							
7 pm							
8 pm							
9 pm							
10 pm							
11 pm							
midnight							
1 am							
2 am							
3 am							
4 am							
5 am							