"Your family's missing piece"

Connecticut Behavioral Consultants

Website Information Form

Basic Information:

Individual's Name: _____ Sex: ☐M ☐F Date of Birth: _____

Parent/Guardian Name: _____

Best method of contact: ☐Phone ☐Email

Contact email/phone number: _____

Town of Residence: _____

General Behavioral Information:

Please indicate all of the challenging behaviors of concern, current frequency and intensity:

Behavior	Y/N	Frequency: Number of times behavior occurs on average per day, week or month (circle one)	Caused injury in the past 12 months?	Required physical intervention in the past 12 months?	Caused property damage in past 12 months?
Self-Injury		_____ Per Day/Week/Month			
Physical Aggression		_____ Per Day/Week/Month			
Property Destruction		_____ Per Day/Week/Month			
Elopement/ Running Away		_____ Per Day/Week/Month			
Ingestion of inedible items		_____ Per Day/Week/Month			
Loud vocalizations		_____ Per Day/Week/Month			
Non-compliance		_____ Per Day/Week/Month			
Arguing					
Tantrums		_____ Per Day/Week/Month			
Stealing		_____ Per Day/Week/Month			
Stereo-typical/repetitive behaviors		_____ Per Day/Week/Month			

Describe the concerns that you have about your child and reason for referring for ABA treatment:

_____

_____

_____

_____

Does your child experience challenges with any of the following (check all that apply):

☐Eating
☐Sleeping
☐Social Relationships
☐Constipation
☐Toileting
☐Anxiety
☐Community Outings
☐Lack of Motivation
☐Attention/Focus
☐Sadness/Depression
☐Anger/Agitation
☐Drug/Alcohol Abuse
☐Transitions

Have any of the following been required to manage your child's behavior (check all that apply):

☐Police involvement
☐Hospitalizations
☐Psychotropic Medication
☐Physical Restraints
☐Seclusion/Time out Procedures
☐School Suspensions
☐Removal from school/extracurricular activities

General Availability for Sessions: Please mark an X in time frames you're generally available for sessions.

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
8 am -12pm							
12pm-4pm							
4pm-8pm							

Basic Insurance Information: Should your child meet our criterion for services, it would be helpful for us to have this insurance information so we can immediately begin the process of getting authorizations. This will allow for less delay when we are ready to begin services.

Primary Insurance Company: _____
Member ID: _____
Group ID: _____
Policy Holder's Name: _____ Date of Birth: _____
Policyholder's Relationship to Individual: _____