****

**Ottawa ABA Academy**
**Intake Client Information Form**
203-900 Greenbank Road, Nepean, ON

Ottawaabaacademy.com

|  |  |
| --- | --- |
| **Client Information** |  |
| **Full Name** |  |
| **Date of Birth** |  |
| **Gender** |  |
| **Address** |  |
| **Parent/Guardian Name(s)** |  |
| **Phone Number** |  |
| **Email Address** |  |
| **Emergency Contact (Name & Phone Number)** |  |
| **OAP Funding & Insurance** |  |
| **Does the client have OAP (Ontario Autism Program) funding?** | Yes/No |
| **If yes, provide OAP reference number** |  |
| **Do you have private insurance coverage for ABA therapy?** | Yes/No |
| **If yes, provide insurance details:** |  |
| **Medical & Developmental Information** |  |
| **Has the client been diagnosed with Autism or any other developmental disorder?** | Yes/No |
| **If yes, provide diagnosis details and date:** |  |
| **Has the client undergone any intellectual or developmental assessments?** | Yes/No |
| **If yes, provide assessment details** |  |
|  |  |
| **Does the client have any allergies?** | Yes/No |
| **If yes, specify allergens and reaction type** |  |
| **Does the client require medication during therapy sessions?** | Yes/No |
| **If yes, list medications** |  |
| **Any dietary restrictions or special eating habits?** |  |
| **Is the client toilet-trained?** | Yes/No |
| **Does the client have any sensory sensitivities?** | Yes/No |
| **If yes, describe sensitivities** |  |
| **Communication & Behavior** |  |
| **Is the client verbal or non-verbal?** | Yes/No |
| **If verbal, how would you describe their communication skills?** |  |
| **If non-verbal, does the client use alternative communication methods (e.g., PECS, AAC device, sign language)?** |  |
| **Does the client exhibit any challenging behaviors?** | Yes/No |
| **If yes, describe behaviors and possible triggers** |  |
| **Has the client previously received ABA therapy?** | Yes/No |
| **If yes, provide details (where, when, and duration)** |  |
| **What previous ABA targets and programs has the client worked on?** |  |
| **Preferred ABA Therapy Schedule** |  |
| **Preferred days for therapy** |  |
| **Preferred times for therapy** |  |
| **Preferred session duration (2 to 7 hours)** |  |
| **Start date preference** |  |
| **School & Educational Information** |  |
| **Is the client currently enrolled in school?** |  |
| **If yes, provide school name and location** |  |
| **Does the client receive any additional support at school (e.g., EA, IEP, resource support)?** |  |
| **Any additional comments or information that may help us provide the best support?** |  |

|  |
| --- |
|  |
|  |
|  |

**Parent/Guardian Signature:**

**Date:**