CTAC Application

Dedicated to Improving the Lives of Children with Autism and Other Developmental Delays

Child Information

Name: _____ Nickname: _____
First Middle Last

Date of Birth: _____ Age: _____ Sex: M F

Home Phone: _____ Social Security Number: _____

Custodial Parent/Guardian: _____

Parent/Legal Guardian Information:

Parent/Guardian #1:

_____ Relationship to Child:_____
First Last

Address:_____ Home Phone:(____)_____

_____ Cell Phone:(____)_____

City:_____ Work Phone:(____)_____

State:_____ Zip:_____ Email:_____

Address same as patient? Y N

Parent/Guardian #2:

_____ Relationship to Child:_____
First Last

Address:_____ Home Phone:(____)_____

_____ Cell Phone:(____)_____

City:_____ Work Phone:(____)_____

State:_____ Zip:_____ Email:_____

Address same as patient? Y N

Will anyone else accompany/drop off/pick up your child? Y N

If yes, please list their contact information:

Name:_____ Phone:(____)_____

Name:_____ Phone:(____)_____

Insurance Information

Primary Insurance Co. Name: _____ Provider Phone #: _____

Policy/Id #_____ Group #_____

Policy Holder's DOB_____ Policy Holder's SSN _____

Relationship to Patient: _____ Employer _____

****In order to submit claims to insurance, CTAC will need a copy of your child's diagnosis and a prescription for ABA Therapy from your physician ****

Family History

Parents are (circle one): Married Living Together Separated Divorced Remarried

Is patient adopted? Y N If yes, at what age and from where/what country? _____

Are other languages spoken at home? Y N If yes, please list: _____

Who lives in the house with the patient? _____

Have there been any instances of the following in your immediate/extended family members? (please circle):

ADD/ADHD Autism/PDD Communication Disorders Mental Illness Learning Disabilities

Other: _____

Are there any cultural/spiritual variables that may impact treatment? Y N If yes, please explain: _____

_____

Medical Information

Child's Primary Diagnosis: _____ Date of Diagnosis: _____ Age: ____

Secondary Diagnosis: _____ Date of Diagnosis: _____ Age: ____

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Other Diagnoses: _____ Date of Diagnosis: _____ Age:_____

Referring Physician/PCP: _____ Phone: (____)_____

May we communicate with the PCP if needed? Y N (If yes, please also indicate on the release form)

Has your child's hearing been screened in the last 6 months? Y N If yes, were the results within normal limits?_____

****Please include copies of any previous assessments or evaluations****

Is your child currently on any medications: YES NO If yes, please list below:

Medication	Date Prescribed	Dosage	Administration Times	Used for

Were there any complications during pregnancy? Y N If yes, please describe:

_____

_____

Length of pregnancy? _____

What was the child's birth weight? _____

Were there any concerns or trauma during birth? _____

_____

Has your child ever been admitted to a hospital/treatment center for psychiatric, medical, behavioral or crisis situations: _____

_____

_____

Has your child been diagnosed with any medical conditions (e.g., infectious diseases, seizure disorders, cerebral palsy, etc.): _____

_____

Does your child have food or other types of allergies: _____

_____

_____

Describe your child's eating habits: _____

_____

_____

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Describe your child's sleeping habits: _____
_____
_____

Is there any history of abuse?_____

Educational Services Information

What school does your child attend? _____

# of students in classroom: _____ Staff to student ratio: _____

Special Education or General Education Days/time of attendance: _____

May we communicate with school? Y N (If yes, please indicate on release form)

School contact information (teacher's email/phone): _____

Does your child have current in-home services? If yes, please describe:
_____
_____
_____

Date started: _____ Public Agency: _____ Private provider: _____

Describe other services and/or activities your child participates in:

Service/Activity/ Provider Info. Date Started Hours/Minutes per week
_____
_____
_____
_____

****Please attach the most recent reports including goals & objectives statements****

Reinforcement/Child Preferences

Describe the items and activities your child enjoys: _____
_____
_____

Identify typical reinforcers in these groups:

Food: _____

Toys: _____

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Praise: _____

Physical Activities: _____

Describe what your child would do if left alone for a period of time: _____
_____
_____
_____

Behavioral Language Assessment

Expressive Verbal Skills

Describe your child's ability to babble speech sounds: _____
_____
_____

Describe your child's spontaneous language: _____
_____
_____

Describe how your child indicates what he/she wants: _____
_____
_____

Describe the type and number of items that your child asks for: _____
_____
_____

Describe your child's ability to imitate vocal sounds, words, phrases: _____
_____
_____

Describe your child's ability to label items, events, or actions (spontaneous? how many? how often?):_____
_____
_____

Describe your child's ability to answer questions: _____
_____
_____

How well is your child understood by familiar and unfamiliar listeners? _____
_____
_____

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Sounds your child has the most difficulty with: _____
_____
_____

Estimate how many words are in your child's vocabulary:

___ under 50 ___ 50-100 ___ more than 100

Receptive Language Skills

Describe your child's ability to follow directions and routines within context or with model: _____
_____
_____

Describe your child's ability to follow directions and routines out of context or without a model: _____
_____
_____

Is your child able to follow directions given to a group of children? _____ How large of a group? _____

Is your child able to select a named item from a field of two or more items? _____

How many items is your child able to identify receptively? _____

Is your child able to select an item from a field of two or more when given a description of the item? _____

Is your child able to receptively identify body parts, colors, big/little? _____

Motor Imitation

Is your child able to imitate simple motor movements such as clapping, waving? _____

Is your child able to imitate actions using objects---using "do this" with a model? _____

Is your child able to imitate finger-play actions with a song? _____With a group? _____

Social Skills

Your child makes eye contact with (circle all that apply): Mom Dad Siblings Familiar people Others

Describe your child's response when addressed by others: _____
_____
_____

Describe your child's interest in being with others (children, adults, familiar, unfamiliar): _____
_____
_____

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Describe your child's interest in doing what others are doing: _____
_____
_____

Describe your child's ability to participate in turn-taking activities: _____
_____
_____

Is your child conversational? Y N Describe: _____
_____
_____

Does he/she get "stuck" on certain topics? Y N Describe:
_____
_____
_____

Play Skills

Describe your child's play with toys (identify the toys and length of time involved): _____
_____
_____

Does your child use the toys as intended or as self stimulatory objects? _____

Describe your child's interactive play with other children: _____
_____
_____

Describe your child's imaginative and pretend play skills: _____
_____
_____

Academic Skills

Check skills that your child is able to demonstrate:

____ Recites Alphabet	____ Labels Each Letter	Counts to _____
____ Counts with one-to-one Correspondence	____ Reads words ____ w/ comprehension	____ Stacks Blocks
____ Completes Simple Puzzles	____ Orders Items Smallest to Biggest	____ Identify Letters Receptively
____ Identify numerals Receptively	____ Labels Numerals up to _____	____ Reading Level

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Fine Motor and Gross Motor Skills

Describe your child's gross motor skills in general: _____

_____

_____

Check the skills your child is able to demonstrate:

____ Throw a Ball ____ Kick a Ball ____ Bounce a Ball ____ Catch a Ball

____ Roll a Ball ____ Raise Arms Up ____ Jump on One Foot ____ Twirl Arms

Describe your child's fine motor skills in general:_____

_____

_____

Check the skills your child is able to demonstrate:

____ Scribbles ____ String Beads ____ Writes Letters ____ Writes Words

____ Draws pictures ____ Uses Scissors ____ Draws Lines ____ Draws Shapes

____ Itsy Bitsy Spider ____ Writes Name

Self-help Skills

Describe how your child feeds him/herself: _____

_____

Does your child wash and dry his/her hands independently? _____

_____

Is your child toilet trained completely? Y N If not, what program did you use or have your tried with your child?_____

_____

Does your child dress independently: Y N Describe: _____

_____

Describe any household tasks that your child assists with: _____

_____

Describe how your child responds to situations of danger: _____

_____

_____

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Challenging Behaviors

Can you tell your child no? Y N If not, describe the behavior: _____
_____
_____

Can you take away reinforcers? Y N If not, describe the behavior: _____
_____
_____

Are you able to take your child to public places? Y N If not, describe your child's behavior in public places:
_____
_____

Can your child wait appropriately? Y N Describe: _____
_____
_____

Does your child follow/comply with instructions in everyday situations? Y N Describe: _____
_____
_____

Describe in general your child's behavior at home: _____
_____
_____

Describe any of the following that pertain to your child and the conditions under which they occur:

Repetitive behaviors: _____

Physical Aggression: _____

Property Destruction: _____

Obsessive/Ritualistic Behaviors: _____

Self Injurious Behavior: _____

Stereotypic Behavior: _____

Unsafe/Dangerous Behavior: _____

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Narrative

Describe your child's development from birth to present (including abilities and how he/she learns best): _____

_____
_____
_____
_____
_____
_____

Expectations/Goals

Rank from 1-5 the order of your prioritized goals and skill areas for your child (eg. Language, socialization, reducing challenging behaviors, play, self-help, toileting):

1._____
2._____
3._____
4._____
5._____

Please indicate your child's weekly schedule including any preferred times and/or times that will **not** work (nap times, preschool, sports practices, sibling activities, other therapy services, etc.) for weekly sessions here at CTAC. This schedule will serve as a guideline, not a guarantee, for CTAC to use when finding a session time that works for best for your child. **For efficacy of treatment, CTAC requires a minimum of 4 hours per week of ABA therapy. ABA sessions typically run 2-4 hours in length.**

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00						
8:30						
9:00						
9:30						
10:00						
10:30						
11:00						
11:30						
12:00						
12:30						
1:00						
1:30						
2:00						
2:30						
3:00						
3:30						
4:00						
4:30						
5:00						
5:30						
6:00						
6:30						

How many total hours were you hoping to receive? _____

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