# Welcome to the Motiv8 Family!

*To ensure the smoothest possible transition into Motiv8 clinics, help us help you! Our process will be expedited if we have the following information as soon as you are able to get them to us! Thank you for your help in getting your family's journey started!

- ❒ Complete and return the initial Intake Information Packet
- ❒ Fill out, sign and return the Release of Information document so we can coordinate with other providers working with your family, including your primary care physician
- ❒ Provide us a copy of your insurance card(s)
- ❒ If seeking ABA services, we will need a copy of your child's diagnostic evaluation report
- ❒ If your child is in school, a copy of his/her Individualized Education Plan (IEP), if applicable
- ❒ Signed Permission for Assessment

420 Viking Drive Reedsburg, WI P: (608)524-9600 F: (608)524-3697

# Initial Intake Information

| | | | | | |
|---|---|---|---|---|---|
| Initial Interview/Screening Completed By: | | Date: | | | |
| **Biographical Information** | | | | | |
| Child's Name: | | | | DOB | |
| | *First* | *Last* | | *M.I.* | |
| Gender | | | | | |
| Referred by: | | | | | |
| **Caregiver Information** | | | | | |
| Responsible Party #1 | | Relationship to client: | | | |
| Address: | | Phone: | Home/Mobile:<br>Work: | | |
| Email: | | Best method of contact: | | | |
| Responsible Party #2 | | Phone: | | | |
| Address: | | Phone: | Home/Mobile:<br>Work: | | |
| Email: | | Best method of contact: | | | |
| *Do you have joint or sole custody?* | | | | | |
| *Siblings in the home:* | | *Ages:* | | | |

**Primary Medical Information**

Medical Diagnosis

| | | | |
|---|---|---|---|
| Name of Diagnosing Clinician: | | Date of Diagnosis:<br>Diagnosis: | |
| Primary Pediatrician: | | Group/ Affiliation: | |
| Address: | | Phone/Fax: | |

| | | | | |
|---|---|---|---|---|
| Date of Last: | Dental Exam: | | Physical: | |
| | Hearing test/ Screening: | | Vision test/ Screening: | |
| | IEP: | | | |

| | | | |
|---|---|---|---|
| Medical Conditions: | | Medications: | |
| Allergies: | | Hospitalizations: | |

Funding Information

Primary Insurance

| | | | | | |
|---|---|---|---|---|---|
| Subscriber name: | | Relationship to client | | DOB | |
| SS# | | Insurance Company | | | |
| Employer Name: | | Employer Address | Street:<br>City/state/zip: | | |
| Member ID/ Policy # | | Group # | | Effective Date: | |

Secondary Insurance (if applicable)

| | | | | | |
|---|---|---|---|---|---|
| Subscriber name: | | Relationship to client | | DOB | |
| SS# | | Insurance Company | | | |
| Employer Name: | | Employer Address | Street:<br>City/state/zip: | | |
| Member ID/ Policy # | | Group # | | Effective Date: | |

Legal/Financially Responsible Party (If different from Primary Insurance Subscriber Name)

| | | | | | |
|---|---|---|---|---|---|
| First & Last name: | | Relationship to client | | DOB | |
| SS# | | Email: | | | |
| Phone: | | Best method of contact | | | |
| Employer Name: | | Employer Address | Street:<br>City/state/zip: | | |

Are there any religious or cultural considerations for treatment? If YES, please explain.

Is your child attending any school, educational, or developmental programs? (Birth to 3, Early Childhood)

Services: SL/PT/OT other (Please write the names, locations, and schedule of visits for the following:

Services: We need a list of all other providers your child is working with (i.e., gymnastics, music lessons, therapies, etc.) We will need their contact information and a release of information for each provider. (For the state funding this is to coordinate services and demonstrate that ours are not duplicating any other service)

*If your child is currently receiving services from another ABA provider, please stop here and contact an office admin. Please Note: In2Great Children's Therapy holds the right to decline services if the child is receiving ABA treatment at another location. If you decide to add ABA services from another provider (other than school service) at any time while being serviced by In2Great, you must let us know immediately. We cannot treat a child with multiple ABA providers.

| Service | Provider | Location | Schedule |
|---|---|---|---|
| ABA Therapy | | | |
| Speech Therapy | | | |
| Physical Therapy | | | |
| Occupational Therapy | | | |
| Others: | | | |

Are there any other known family members w/ ASD or related diagnoses (ADD, ADHD, Bipolar, anxiety, depression, etc.)?

| Health History: | | | |
|---|---|---|---|
| Prenatal/Birth History: | Born at how many weeks? | | |
| | Complications? | | |
| Medical History | Major Illnesses/ Hospitalizations | | Date: |
| | Recurring medical issues? | | |

| Developmental History: | | | |
|---|---|---|---|
| At what age did your child: | Sit up: | Crawl: | Walk: |
| | Say first word | Combine words: | |
| | | | |

| Sleep History: | | | |
|---|---|---|---|
| At what age did your child begin to sleep through the night? | | How many hours per day does your child sleep, on average? | |
| Does your child fall asleep on their own? | | Bedtime? Wake? | |

| Communication: |
|---|
| Roughly, how many words can your child say? |
| Do you have difficulty understanding your child? |
| Does your child get frustrated when someone doesn't understand what he/she is trying to say? |

| Community: When in the community, does your child: | | | |
|---|---|---|---|
| Stay near you, without needing frequent reminders? | | Tolerate and respect 'no', when they are told they can't have something? | |
| Transition between people, places and activities? | | Follow 'social rules' (i.e., quiet in the library, walking in a store, etc.)? | |

Please list some HIGHLY reinforcing items that your child enjoys.

| Foods | Activities | Shows/Characters | Social Interactions | Toys/Games/ Objects |
|---|---|---|---|---|
| | | | | |

If your child could do any two things all day long, what would they be?

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

| Play/ Social: | | | |
|---|---|---|---|
| What does your child enjoy doing? | | Does he/she enjoy doing those things with other children? | |
| Are there activities that frighten your child? | | How long will your child tolerate being with other children? | |

Behavior:

What are some behaviors of concern you have for your child that you want to see **decrease**? (i.e. hitting others, throwing objects, scratching people, swearing, biting, hand flapping, etc.).

| Behavior | When does it occur? | How long does the behavior last? | How often does the behavior occur? | How do you/others respond to the behavior? |
|---|---|---|---|---|
| *Example: Hitting* | *When told 'no' When wants something* | *15-30 minutes* | *2 times per week* | *We ignore the behavior* |
| | | | | |
| | | | | |
| | | | | |

Perseverative and Repetitive Behaviors? (gets stuck on)/self-stimulatory behaviors (repetitive behaviors, things your child does over and over. Examples: walking on tip toes, looking out corner of eye, opening/closing doors, turning off/on lights)? What type of behaviors have you seen?

What are some behaviors you want to see **increase** in your child's repertoire? (i.e., compliance, communication, social skills, joint play).

Please list the top three areas of concern that you would like your child's therapy to address, or three goals that you would like to see your child/family meet:

1.

2.

3.

Please indicate/check your child's level of independence with each of the following skills:

| **Self-Help:**<br>*Dressing (Shirt, pants, socks, shoes, on and off), feeding (drink from a straw, cup, eat with utensils, clean-up), Hygiene (washing hands/face/body, brushing hair/teeth, blowing nose), Toileting* | | |
|---|---|---|
| ☐ *Completely independent with dressing, feeding, hygiene, and toileting skills.* | ☐ *Needs assistance in some areas or with some items:*<br>*Please list: _____* | ☐ *These skills all require a great deal of assistance to complete successfully.* |
| Comments: | | |
| **Receptive Language:**<br>*Listening to and following directions, responding to name, selecting pictures/vocabulary* | | |
| ☐ *Can understand and follow all directions with little to no help.* | ☐ *Requires prompts to follow directions* | ☐ *Will not follow verbal directions or needs help to do what is asked* |
| Comments: | | |
| **Communication:**<br>*Vocalizations, requests, conversation, gestures, asking for help* | | |
| ☐ *Independent with requesting, labeling items, and having conversations.* | ☐ *Requires prompting to communicate needs and wants or does so nonverbally.* | ☐ *Communicates only through gestures, leading, or behavior.* |
| Comments: | | |
| **Social Interactions:**<br>*Playing with other children, sharing toys, plays appropriately with toys, takes directions from peers, returns greetings, maintains interactions with peers.* | | |
| ☐ *Engages socially as other children his/her age.* | ☐ *Needs reminders while interacting with other children.* | ☐ *Needs constant supervision while interacting with other children.* |
| Comments: | | |
| **Academics:** | | |
| ☐ *Completing grade-level academic work with his/her peers.* | ☐ *Slightly behind grade-level academics and/or is unable to complete work with his/her peers.* | ☐ *Significantly behind his/her peers, academically.* |
| Comments: | | |

| Please list your child's availability for therapy sessions- Place an (X) in the box if you ARE available | | | | | |
|---|---|---|---|---|---|
| Time | Monday | Tuesday | Wednesday | Thursday | Friday |
| 8:00 am- 9:00 am | | | | | |
| 9:00 am- 10:00 am | | | | | |
| 10:00 am- 11:00 am | | | | | |
| 11:00 am- 12:00 pm | | | | | |
| 12:00 pm- 1:00 pm | | | | | |
| 1:00 pm- 2:00 pm | | | | | |
| 2:00 pm- 3:00 pm | | | | | |
| 3:00 pm- 4:00 pm | | | | | |
| 4:00 pm- 5:00 pm | | | | | |
| 5:00 pm- 6:00 pm | | | | | |

# Release of Information

Client Name: Date of Birth:

For the purpose of accessing client history, diagnosis, coordination of care, and treatment planning, I, the undersigned, hereby authorize Motiv8 Children's Therapy to release to, receive from, and verbally exchange records containing my or my dependent's personal health information and other confidential information with the individuals below:

| *Provider Name* | *Address (street, city state, zip)* | *Phone, Fax, Email* |
|---|---|---|
| *Physician or Pediatrician* | | |
| *Early Intervention, Birth-3* | | |
| *School* | | |
| *Case Coordinator* | | |
| *Other Caregivers* | | |
| *Other* | | |

Information to be released may include verbal and email exchange, diagnostic or testing reports, current assessment reports, treatment plans, treatment data, or progress reports for the purpose of coordination of care. This may also include applicable medical history, client history, medication history, allergy records, consultations, session notes, previous assessments, treatment plans, or progress reports.

I understand that Motiv8 Children's Therapy is required by law to keep all client information confidential. If I have authorized the disclosure of information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal privacy laws and the information may be disclosed.

I understand that this authorization is voluntary and Motiv8 Children's Therapy cannot make conditional client eligibility for benefits, treatment, enrollment, or payment on the signing of this authorization.

In compliance with state statutes, which require special permission to release otherwise privileged information, I authorize the release of records pertaining to mental health and developmental disabilities from my child's date-of-birth to the expiration or withdrawal of this authorization.

I understand that I do not need to sign this authorization in order to receive treatment and services from Motiv8 Children's Therapy, that I have a right to receive a copy of this authorization for my records, and that I may revoke this authorization at any time.

I understand and agree that this authorization to disclose protected health information shall be in effect during the entire time that client receives services from Motiv8 Children's Therapy. I understand that I am solely responsible for updating Motiv8 Children's Therapy of any changes to this authorization via completing a new authorization, and hereby waive any claims against Motiv8 Children's Therapy for any inadvertent disclosure to any person listed on any outdated authorization.

On behalf of the minor client identified above who is under the age of 18 or is legally conserved, I consent to receive treatment and Services from Motiv8 Children's Therapy.

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____