www.nolansplace.com
320.403.5247

NOLAN'SPLACE

WHERE AUTISM IS EMBRACED

INTAKE PACKET

Dear Parent(s)/Guardian(s):

Thank you for your interest in our autism therapy services at Nolan's Place. We provide early intensive behavior and developmental intervention using the principles and techniques of Applied Behavior Analysis (ABA) to bring about meaningful and positive change in your child's behavior. It is our mission to support children and families affected by autism spectrum disorder in a way that allows them to make gains toward their greatest potential. The areas of focus are tailored to each specific child, but may include the following skills: social, play, cognitive, adaptive, language, motor, executive functioning, behavior management, and healthy family functioning. With Nolan's Place, children receive individualized 1:1 treatment that focuses on their specific needs, skills, interests, and family situation. Your therapy hours will depend on your child's age, abilities, needs, and our current staff availability.

This intake paperwork that you will be completing will help familiarize you with our policies and procedures regarding our ABA services. Additionally, the information you provide in this packet will help us in getting to know you and your child. We ask that you please take your time to review the information in this packet and to answer each question as thoroughly as possible.

At times, we do have a waiting period for children to receive our services. In order to be placed on the waitlist, please complete this intake packet in its entirety and provide us with a copy of the requested documents.

Please note that Nolan's Place services are funded through insurance. We accept state funded plans as well as limited commercial insurance plans when mental/behavioral health benefits are included. Certain Medical Assistance (MA) programs cover the cost of our services. This includes MCOs, straight MA, and the TEFRA MA option. It is required that you carry insurance coverage *at all times* for your child while they are attending Nolan's Place. If there is a lapse in coverage, it will affect your child's ability to receive therapy. Please be sure to include your child's current insurance information in the intake packet to be placed on our waitlist.

We would like to thank you for your interest in receiving services from Nolan's Place. ABA treatment is about teamwork and we value you as part of the team. Therefore, if at any time in this process you have any questions, please feel free to reach out and we will be glad to help you.

PLEASE INCLUDE COPIES OF THE FOLLOWING DOCUMENTS: (*Note that your review may be delayed if the following documents are not turned in with the packet. Please communicate immediately if you do not have copies of the documents and we will work with you to obtain them. Check below.)

Included:	Important Documents:
	Diagnostic assessment (previous and/or current)
	Individual Education Plan (IEP) from school, if applicable
	School evaluation, if applicable
	Well Child Check
	Medical Records (hearing, vision, ENT, genetics, etc.)
	Therapy Records (SLP, OT, PT, psychiatric, etc.)
	Any previous EIDBI assessments and treatment plans
	Insurance Card

CLIENT INFORMATION

Please complete this information regarding your child. Feel free to add any additional information or attach additional reports that you think may be helpful for us in getting to know your child. Nolan's Place views all of the information that you provide us with as strictly confidential. This information is helpful for us in developing an initial understanding of your child's needs and provides critical information for us to discuss with your insurance company to get authorization for services.

Today's Date: _____

GENERAL INFORMATION

Name of Person Completing this Form: _____

Relationship to Child: _____

Legal Name of Child: _____

Child's Date of Birth: _____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian 1 Name : _____
Address: _____
_____
Phone: _____
Email: _____
Employer: _____

Parent/Guardian 2 Name : _____
Address: _____
_____
Phone: _____
Email: _____
Employer: _____

Emergency Contact_____ Relationship_____ ____
Address_____ Phone _____

FEDERAL REPORTING DEMOGRAPHIC INFORMATION (Optional)

Child's Gender: _____

Child's Race/ethnicity (check all that apply):

☐ American Indian or Native Alaskan ☐ Pacific Islander or Native Hawaiian

☐ Asian ☐ White

☐ Black or African American ☐ Other (please specify): _____

Is your child Hispanic or Latino? _____

Primary language: _____

Are there any cultural considerations that need to be taken into account or that we should be aware of?
_____
_____
_____

INSURANCE INFORMATION
****** Please provide us with a copy of the front and back of your insurance card(s)***

Primary Insurance Provider:

Name of Insurance Company: _____

Name of Policy Holder: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____

Insurance Address: _____
_____
_____

Phone Number: _____

Member ID:_____ Group ID: _____

Secondary Insurance Provider:

Name of Insurance Company: _____

Name of Policy Holder: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____

Insurance Address: _____
_____
_____

Phone Number: _____

Member ID:_____ Group ID: _____

Medical Assistance (Straight MA or TEFRA):

Medical Assistance Number: _____

Does your child currently receive any services through the county?

☐ Yes (Please provide information below.)
☐ No

Name of **County Case Manager/Social Worker**: _____

Provider Address: _____
_____
_____

Provider Phone Number: _____ Email: _____

Type of services received (check all that apply):

☐ Social Worker/Case Manager
☐ Consumer Support Grant
☐ Family Support Grant
☐ DD Waiver
☐ CADI Waiver
☐ Other: _____

Does your child have a current diagnosis of autism spectrum disorder (F84.0)?
◯ Yes ◯ No
* If yes, please provide information below
* If no, is your child currently on a waiting list to be evaluated for ASD? When and where is that assessment taking place?

Does your child have any other mental health diagnosis (ADHD, anxiety, depression, etc.)
◯ Yes ◯ No
* If yes, please provide the following information:

Diagnosis	Diagnosing Physician	Date Diagnosed	Diagnosis Code

Please note that the diagnosis information is required for insurance coverage. By having this information, it assists us when speaking with your insurance company to get authorization for services and providing you with invoices for reimbursement through insurance.

Child/Adolescent's Current Height: _____ft. _____in. Weight: _____lbs.

Which hand does your child/adolescent show dominance? ☐ Left ☐ Right ☐ Unknown

Does your child/adolescent have any current health conditions, including infectious diseases?
☐ Yes ☐ No

* If yes, please explain below.
_____
_____
_____

Has your child had any of the following tests or evaluations? Please ***provide copies*** if any of the following were completed:

Evaluation	Date	Where was it done?	What were the results?
Psychology or Neuro-Psychology			
Brain wave test, EEG, electroencephalogram CT or MRI of the head			
Blood Chromosome Test			
Blood test for fragile X Syndrome			
Previous evaluations for autism			
Other evaluations			

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child/adolescent has had:

Does your child/adolescent have any vision problems? ☐ Yes ☐ No

* If yes, please explain below and if there are any treatments currently being used for correction:

Does your child/adolescent have any hearing problems? ☐ Yes ☐ No

* If yes, please explain below and if there are any treatments currently being used for correction:

Does your child/adolescent have a history of seizures? ☐ Yes ☐ No

* If yes, please describe the types of seizures and current treatment:

Is your child/adolescent currently taking any medications? ☐ Yes ☐ No

* If yes, please provide the following information:

Name of Medication	Amount	Start date	When is the medication taken?	Reason for medication?	Prescribing Physician

Does your child have any allergies to medications? ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions:

Does your child have any other allergies (seasonal, food, etc.)? ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions and if any epi pen is needed:

_____

CURRENT/PREVIOUS THERAPY PROVIDER INFORMATION

Please provide us with information regarding the following types of current or previous therapy providers and copies of any recent evaluations that indicate dates of previous treatment and therapeutic interventions and responses.

Does your child currently receive behavioral services with another provider?

☐ Yes (Please provide information below.)

☐ No

Name of **Behavioral Provider**: _____

Provider Address: _____

_____

_____

Provider Phone Number: _____ Email: _____

Does your child currently receive speech therapy services?

☐ Yes (Please provide information below.)
☐ No

Name of **Speech Therapy Provider**: _____

Provider Address: _____
_____
_____

Provider Phone Number: _____ Email: _____

Does your child currently receive occupational therapy services?

☐ Yes (Please provide information below.)
☐ No

Name of **Occupational Therapy Provider**: _____

Provider Address: _____
_____
_____

Provider Phone Number: _____

Does your child currently receive physical therapy services?

☐ Yes (Please provide information below.)
☐ No

Name of **Physical Therapy Provider**: _____

Provider Address: _____
_____
_____

Provider Phone Number: _____ Email: _____

Does your child currently receive any other services?

☐ Yes (Please provide information below.)

☐ No

Name of **Other Provider**: _____

Provider Address: _____

_____

_____

Provider Phone Number: _____ Email: _____

_____

EDUCATIONAL HISTORY

Please list all schools your child has attended in order starting with the most current school.

Name of School	School System	Year(s)	Grade	Special Education Services
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

**** Please provide us with copies of any reports from initial special education evaluations that you may have, as well as a copy of the current 504 plan or IEP.***

_____

FAMILY BACKGROUND

Does either parent/guardian's job require him/her to be away from home for long hours or extended periods of time that might prevent them from being involved in ABA services and parent training?

☐ Yes ☐ No

* If yes, which parent/guardian and for how long? _____

Marital Status:

☐ Married
☐ Civil Union
☐ Remarried
☐ Divorced
☐ Separated
☐ Widowed
☐ Single
☐ Cohabitants

* If divorced, who has legal custody? _____ Is it full or joint custody? _____

Does your child have siblings? ☐ Yes ☐ No
* If yes, please provide the following information:

	Name	Age	Relationship	Living in Home?	School	Grade
1.				☐ Yes ☐ No		
2.				☐ Yes ☐ No		
3.				☐ Yes ☐ No		
4.				☐ Yes ☐ No		
5.				☐ Yes ☐ No		
6.				☐ Yes ☐ No		

Please indicate and describe whether any of the siblings have any special needs, diagnoses, or concerns.

Are you also interested in seeking services for any of the siblings with special needs?
☐ Yes ☐ No ☐ Not applicable
*If yes, you will need to complete a new intake packet for that child.

Are there any other individuals residing in the house or that play a significant role on how this child is raised?
☐ Yes ☐ No
* If yes, please identify who else is involved in raising the child and their relationship to the child.

Does your child currently take naps?
☐ Yes ☐ No
*If yes, how often? _____ How long? _____

PSYCHOLOGICAL HISTORY

Please indicate below whether or not there is a history of the following in your immediate family or in either biological parent's extended family.

Yes	No	
☐	☐	Autism Spectrum Disorders
☐	☐	Learning Problems/Disabilities
☐	☐	ADD/ADHD-Attention Problems
☐	☐	Clinical Depression
☐	☐	Bipolar Disorder
☐	☐	Behavior Problems in School
☐	☐	Anxiety Disorders (e.g., OCD, etc.)
☐	☐	Intellectual Disability
☐	☐	Psychosis/Schizophrenia
☐	☐	Substance Abuse/Dependence
☐	☐	Other Mental Health Concerns (Please specify:_____)

If yes, please indicate who in the family currently has or has had these diagnoses:

Has your child had an outside psychological or psychiatric evaluation? ☐ Yes ☐ No

Has your child ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

_____

BIRTH AND DEVELOPMENTAL HISTORY

Did the birth mother receive regular prenatal care? ☐ Yes ☐ No

Were there any complications with the pregnancy? ☐ Yes ☐ No
* If yes, please describe the complications below and treatment details.

Was birth at full term? ☐ Yes ☐ No
* If no, please provide details.

What was the type of delivery? ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section

Were there any complications during delivery? ☐ Yes ☐ No
* If yes, please describe the complications below and treatment details.

What was your child/adolescent's birth weight? _____lbs. _____ oz.

Were there any concerns at birth? ☐ Yes ☐ No
* If yes, please describe the concerns and treatment details:

Developmental History	**Age in Months**	**Not Yet**
When did your child start crawling?		
When did your child walk alone?		
When did your child say their first 5-6 words?		
When did your child start to say something meaningful (two to three words together)?		
When did your child potty train for urine? (Age in years)		
When did your child potty train for bowels? (Age in years)		

Describe your child's infancy (sleeping, eating, crying habits, easy or difficult to care for, etc.):

Describe your child's toddler years (language use, playing with others, temper tantrums, sleep routine or lack of, easy or difficult to care for, ability to navigate changing routines):

Describe the time of your initial concerns about your child. What were your concerns? Were they seen by a provider at that time? If so, who?

CURRENT BEHAVIORAL CONCERNS

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply):

☐ Aggression (specify below)
- ☐ Hitting (e.g., punch, slap, etc.)
- ☐ Kicking
- ☐ Biting
- ☐ Pinching
- ☐ Head-butting
- ☐ Scratching
- ☐ Spitting
- ☐ Other (Please specify): _____

☐ Self-Injurious Behavior (specify below)
- ☐ Hitting self with hands or fists (Where on body?:_____)
- ☐ Kicking self (Where on body?: _____)
- ☐ Biting self (Where on body?:_____)
- ☐ Head-butting walls, windows, etc.
- ☐ Pulling teeth
- ☐ Scratching skin
- ☐ Cutting/burning

☐ Other (Please specify): _____

☐ Property Destruction (describe:_____)

☐ Eloping (i.e., running out of a building, room, vehicle, etc.)

☐ Sensory issues - describe:

_____

_____

☐ Sexualized behaviors - describe:

_____

_____

☐ Self-urinating/defecating

☐ Fecal smearing

☐ Rectal digging

☐ Difficulty with toileting

☐ Defiance or problems with authority

☐ Problems with eating

☐ Tantrums

☐ Screaming/yelling

☐ Vocalizations

☐ Repetitive behaviors

☐ Other (Please specify): _____

Additionally, please indicate if your child is experiencing any of the following (check all that apply)?

☐ Isolated socially from peers
☐ Difficulty making friends
☐ Problems keeping friends
☐ Sleep problems (describe: _____)
☐ Bedwetting
☐ Fire setting
☐ Anxiety
☐ Sadness or depression
☐ Hallucinations
☐ Delusions
☐ Suicidal ideation/attempts
☐ Legal situations
☐ History of physical abuse
☐ History of sexual abuse
☐ Alcohol use/abuse
☐ Drug use/abuse including nicotine and/or illegal drugs (list drugs: _____)
☐ Difficulty concentrating

Are there any current or past relevant legal issues pending with your child/adolescent?
☐ Yes ☐ No * If yes, please describe below.

What changes would you like to see for your child and/or family while engaging in a behavioral program?

Are there any cultural or spiritual beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? ☐ Yes ☐ No * If yes, please describe below.

Understanding Nolan's Place's Introductory Trial Period:

If your child is recommended for therapy at Nolan's Place, the first 30 days of service will be considered a trial period during which the center's clinical team will evaluate whether Nolan's Place's services are an appropriate fit for your child's needs. If it is deemed that Nolan's Place is not an appropriate fit for your child, Nolan's PLace will make every attempt to assist you by recommending alternative service providers.

In addition to the information you have provided in this intake packet, please complete the following consents for release of information for each speciality service you listed above. This includes, but is not limited to, neurological evaluation, autism diagnostic assessments, IEP initial assessment and progress reports, current well child check, therapy (Speech, OT, PT) evaluation and last progress notes, and other relevant medical records.

AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

Note: Parent(s)/Guardian(s), this form allows information about your child's complete health record to be exchanged between the mentioned parties. Please sign and return it to Nolan's Place. Use a new form for each provider.

Client's Full Name: _____ Date of Birth: _____

Parent Name: _____

Address: _____

We hereby authorize Nolan's Place to release and exchange information with _____ (***School District and Name***) for the purpose of all EIDBI services, individualized treatment plan development, diagnostic information, medical prescription information, other medical conditions, and other pertinent medical information as it relates to our services. This may include, but is not limited to the following:

Comprehensive Evaluation	Hearing Report	Occupational Therapy Report
Health records	Vision Report	Genetic Report
Psychological Report	Physical Therapy Report	Official school records
Medical Reports	Speech Report	

I understand that this authorization takes effect on the date it is signed. It expires one year from the date of the signature below, unless earlier revoked/canceled in writing.
I understand that I may change this authorization at any time.
I understand that I may cancel this authorization at any time. Cancellation will not change releases that happen before the cancellation date.
Nolan's Place will not restrict my treatment if I choose not to sign this authorization. By signing this authorization, you release Nolan's Place from any and all liability resulting from a redisclosure by the recipient. By signing this authorization, I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on me signing this authorization. Your signature indicates that you have read and understand this form and authorize release of your information as described above.

Parent/Guardian: _____
(Print Name)

Parent/Guardian: _____ Date: _____ / _____ / _____
(Signature)

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Client's Full Name: _____ Date of Birth: _____

Parent Name: _____

Address: _____

We hereby authorize Nolan's Place to release and exchange information with _____ (***Primary Care Facility Name***) for the purpose of all EIDBI services, individualized treatment plan development, diagnostic information, medical prescription information, other medical conditions, and other pertinent medical information as it relates to our services. This may include, but is not limited to the following:

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(Print Name)

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(Print Name)

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(Signature)

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(Signature)

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(Signature)