BEHAVIOR TLC

BEHAVIOR THERAPY & LEARNING CENTER

Client Information Form

I. General Information

Activities Interested In:

☐ Day Program ☐ Consultation ☐ Social Skills

☐ School/Education Consultation ☐ After-school program ☐ Camp TLC

How did you hear about us?

☐ Facebook ☐Web search ☐ Referral

☐ Expo/Symposium _____ ☐ Other: _____

Client

Name: _____ DOB: _____
(First and Last) (Month/Day/Year)

Address: _____ Age: _____
(Street)

_____ Social Security Number: _____
(City, State, Zip)

All Diagnoses: _____

Parent/Guardian

Names: _____ _____ _____
(Mother) (Mom's cell) (Mom's Work)

_____ _____ _____
(Father) (Father's cell) (Father's Work)

Emails: _____ _____

II. Health and Emergency Information

Is your child on a special diet? Please explain._____

Please list any medications your child is on: _____

Does your child have any allergies? Please list. _____

Is your child medically fragile? Please describe. _____

Is your child independent in toileting? Please describe. _____

Is your child physically handicapped, requiring the need for any special accommodations? Please describe.

_____

In case of emergency Behavior TLC should call:

1. _____ _____ _____
(Name) (Number) (Relationship)

2. _____ _____ _____
(Name) (Number) (Relationship)

Responsible persons authorized for pick up and drop off other than legal guardian (will need to verify their identity at pick up):

1. _____ _____ _____
(Name) (Number) (Relationship)

2. _____ _____ _____
(Name) (Number) (Relationship)

Any other Health Information that is important for Behavior TLC to know:

_____

III. Academic Information

School District: _____ Grade: _____

Campus: _____ Classroom Type: _____
(General Ed., Life Skills, Resource, etc.)

Academically Strong Areas:

_____

_____

Academically Weak Areas:

_____

_____

Mode of Communication:
☐ Verbal ☐ Sign Language ☐ Picture Exchange ☐ Combination

Description: _____

IV. Behavioral Information

Problem Behaviors:

☐ Aggression ☐ Self-Injurious ☐ Runs from assigned areas

☐ Throws objects ☐ Property Destruction ☐ Pica (eats nonfood items)

☐ Tantrums ☐ Spits

Other:

_____

_____

How do you usually handle these problem behaviors?

_____

What are the top two behaviors you'd like to see decrease?

_____

Reinforcers:

☐ Salty Foods ☐ Sweet Foods ☐ Toys

☐ Praise/Attention ☐ Frequent Breaks ☐ Peer Interactions

Describe the things your child has high preference for and might work for:

_____

_____

V. General Summary

Tell us anything else about your child that you would like his/her therapists/counselors to know to better help them work together.

_____

_____

_____

_____