Life's WORC
Family Center for Autism
A Light at the End of the Spectrum™

CLIENT SCREEENING FORM

Please check which service you are interested in:

Applied Behavior Analysis (ABA) ( ) Social Skills Training ( )

Before a therapy assessment can take place, we need ***written confirmation of diagnosis.*** *There should be a diagnostic* ***assessment and/or MD prescription stating the diagnosis and referral for ABA or Social Skills Training assessment***

Client Name:	DOB:
Insurance Company:	Insurance Policy ID:
Policy Holder Name:	DOB:
Diagnosis: F84.00, ASD	Address:
Home Phone:	Cell Phone:

Question	Answer If Yes, please explain:
1. Does the client have any history of anxiety?	☐ Yes ☐ No _____ _____ _____
2. Does the client have any history of depression?	☐ Yes ☐ No _____ _____ _____
3. Does the client have any history of suicidal ideations or acts?	☐ Yes ☐ No _____ _____ _____
4. Does the client have any history of homicidal threats or acts?	☐ Yes ☐ No _____ _____ _____
5. Does the client have any experience of being physically or sexually abused?	☐ Yes ☐ No

	_____ _____ _____
6. Does the client have any experience with being the perpetrator of sexual or physical abuse?	☐ Yes ☐ No _____ _____ _____
7. Does the client have a PCP?	☐ Yes ☐ No If Yes, please list the name and telephone number of the PCP:_____ _____ _____
8. Does the child have a history of childhood illness?	☐ Yes ☐ No _____ _____ _____
9. Please list any current medical treatments/ medications the client is receiving:	1. 2. 3.
10. Has the client sought treatment for their autism diagnosis in the past (including Early Intervention)?	☐ Yes ☐ No _____ _____ _____
11. If yes, list any community based programs or assistance used:	1. 2. 3.
12. Has the client been or is being seen by another behavioral health clinician?	☐ Yes ☐ No _____ _____ _____
13. List the presenting problems, noting the reasons the client is entering The Family Center for Autism's program and the psychological and social conditions affecting their status:	1. 2. 3.
14. Does the client exhibit any of the following behaviors?	
Biting	☐ Yes ☐ No
Head Banging	☐ Yes ☐ No
Tantrum	☐ Yes ☐ No
Scratching	☐ Yes ☐ No
Property Destruction	☐ Yes ☐ No
Aggression towards Others	☐ Yes ☐ No
Inability to focus or stay on task	☐ Yes ☐ No
Impulsivity	☐ Yes ☐ No
Difficulty Transitioning	☐ Yes ☐ No
Rocking	☐ Yes ☐ No

Spinning	☐ Yes ☐ No
List any others:	1. 2. 3.
15. Does the client have a history of or current diagnosis of any infectious disease?	☐ Yes ☐ No If yes, please identify:_____
16. Does the client have any allergies (food or medication)?	☐ Yes ☐ No If yes, please identify:_____
17. List all family members or related providers involved in the clients treatment for this diagnosis (explain their capacity - including parents or guardians):	1. 2. 3.
18. Does the client have any family member with a history of medical or behavioral health concerns?	☐ Yes ☐ No _____ _____ _____
19. Approximately how many hours of ABA are requested for the client/family? Please list available days and times. *Note: Research findings regarding the intensity required to produce positive outcomes may require a high number of therapy hours.*	
20. List all sources of support, barriers and influence that may impact the client and family:	
Vocational	
Spiritual	
Cultural	
Educational	
Relevant Legal Matters	Divorce ☐ Custody ☐ Records Subpoenaed ☐
For clients over the age of 12 <u>ONLY</u>: If Yes, please explain:	
Does the client drink alcohol?	☐ Yes ☐ No If yes list amount/type:
Has the client ever felt he/she ought to cut down on drinking?	☐ Yes ☐ No
Does the client use drugs?	☐ Yes ☐ No If yes list amount/type:
Has the client ever felt he/she ought to cut down on the use of drugs?	☐ Yes ☐ No

	_____ _____ _____
Has the client ever felt bad or guilty about drinking or drug use?	☐ Yes ☐ No _____ _____ _____
Has the client ever had a drink or used drugs first thing in the morning to steady their nerves, to start their day or to get rid of a hangover (eye-opener)?	☐ Yes ☐ No _____ _____ _____

☐ I hereby consent for my family member(s) file and case to be reviewed with the PCP listed above, for communication and collaboration purposes.

☐ I hereby refuse consent for the release of information to the PCP.

Parent/Guardians Name: _____

Signature: _____ *on (date):* _____

OFFICE USE ONLY

Are any additional services or referrals needed?

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