

Manding assessment

Can your child ask for things he/she wants with words? Cookie, juice, ball, push me, etc? _____

If yes, please list the items/activities the child can request with words: _____

If your child cannot ask for things he/she wants or needs, how does he/she usually let you know what they want?

Crying/tantrums/gestures/pulling an adult/pointing/sign language, etc: _____

Tacting assessment

Can your child label things in a book or on flashcards: _____

Can your child label common items in their environment, like couch, TV, shoe, etc: _____

If yes, please estimate the number of things your child can label and give a few examples: _____

Echoic assessment

Can your child imitate single words you say? For example, if you say "Say Ball" will he/she say "Ball"? Will he/she imitate phrases: _____

Does your child say things he/she has memorized from movies or things he/she has heard you say in the past? If yes, please describe: _____

Intraverbal assessment

Can your child fill in the blanks to songs? For example, if you sing "Twinkle, Twinkle Little ____" will your child say "Star":

Please list songs or words that your child can fill in: _____

Will your child fill in the blanks to fun and/or functional phrases such as filling in "Pooh" when he/she hears "Winnie the ____" or say "Bed" if asked "What do you sleep in?": _____

Will your child answer WH questions (with no picture or visual cue) such as "What flies in the sky", "What goes in the kitchen": _____

Can your child name at least 3 colors or animals if asked: _____

Imitation assessment

Will your child copy your actions with toys if you tell him/her "Do This"? For example, if you take a car and roll it back and forth and tell your child "Do This" will your child copy you: _____

Will your child copy motor movements such as clap hands or stomp feet if you do it and say "Do This": _____



Child's Name _____

Visual Skills Assessment

Will your child match identical objects to objects, pictures to pictures, and pictures to objects if you tell him/her to "match": _____

Can your child complete age appropriate puzzles: _____

Behavior Assessment

Is your child currently able to sit at a table or on the floor and do simple tasks with an adult: _____

Please list any problem behaviors (crying, biting, hitting, kicking, injuring self, property destruction, etc) that your child displays that you are concerned about: _____

Please estimate the number of times these behaviors happen (100 times a day, 10 times a week, 1 time per hour, etc), as well as a few examples of when the behavior occurs: _____

Describe what strategies you have tried to control these behaviors and whether or not the strategies were successful:

Cultural Considerations

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.: _____

Spiritual Considerations

Please describe below important spiritual practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.: _____

Legal History

Please describe any relevant legal issues you are involved in that you believe are important for us to be aware of prior to initiating a therapeutic relationship.: _____



Child's Name _____

Psychological History

Is there a history in your immediate or in the mother's or father's extended family, of the following? If so, who?

- Yes _____ No _____ Who _____ Autism Spectrum Disorders
- Yes _____ No _____ Who _____ Learning Problem/Disabilities
- Yes _____ No _____ Who _____ ADHS - ADD - Attention Problems
- Yes _____ No _____ Who _____ Depression & Manic-Depression
- Yes _____ No _____ Who _____ Behavior Problems in School
- Yes _____ No _____ Who _____ Anxiety Disorders (OCD, Phobias, etc.)
- Yes _____ No _____ Who _____ Mental Retardation
- Yes _____ No _____ Who _____ Psychosis/Schizophrenia
- Yes _____ No _____ Who _____ Substance Abuse/Dependence
- Yes _____ No _____ Who _____ Other Mental Health Concern (please list)

Coordination of Care and Release of Information

Is your child currently receiving behavioral health and/or therapy services or has received these services in the past? _____

If yes, please list services date range below.

Please list and provide contact info for all other providers for your child:

- Primary care provider: _____ Contact: _____ Dates: _____
- School teacher: _____ Contact: _____ Dates: _____
- Speech Language Pathologist: _____ Contact: _____ Dates: _____
- Occupational Therapist: _____ Contact: _____ Dates: _____
- Behavioral Health Clinician: _____ Contact: _____ Dates: _____
- Social Skills Groups: _____ Contact: _____ Dates: _____
- Parent/Child Support Group: _____ Contact: _____ Dates: _____
- Social Services: _____ Contact: _____ Dates: _____
- Other: _____ Contact: _____ Dates: _____

I **do not** authorize Beach Kids Therapy Center to release client therapy records regarding medical procedures, prescriptions, medical precautions and/or contraindications, or treatment to the following providers listed below:



Child's Name _____

Does your child have any of the following documents:

504 Plan _____ IEP _____ Behavior Intervention Plan _____ Physical Therapy Evaluation _____
Occupational Therapy Evaluation _____ Speech Therapy Evaluation _____ Psychological Evaluation _____

Informed Consent for Treatment

The approach to behavioral intervention will utilize Applied Behavior Analysis (ABA) principles. ABA is the use of behavioral methods to measure behavior, teach functional skills, and evaluate progress. A unique plan will be created that results in long-lasting positive outcomes and an enhanced quality of life. Behavioral treatments are clinical processes that involve a professional arrangement. Therapy is regulated by laws, ethics, your rights as a client, and by standard business practices. Before intervention can begin, your agreement to the business practices described herein is required.

Treatment Termination

If at any time during the course of your treatment it is determined services cannot continue, a Transition to Termination notice can be provided to you explaining the justification for this decision. Ideally, services end when treatment plan goals have been achieved. Additional conditions of termination can include:

- You have the right to stop treatment at any time. If you make this choice, referrals to other therapists may be provided (if available).
- Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. If it is determined that the services are not proving to be clinically beneficial, ethical conduct requires a termination of treatment.
- Other legal or ethical circumstances may arise and lead to termination of treatment, such as the clinical expertise of the Consultant being inappropriate or insufficient for the client/individual receiving treatment. Please note: the Consultant will not diagnose, treat, or advise on problems outside the recognized boundaries of her competencies.
- Other situations that warrant termination may include: drug abuse, disclosing illegal intentions or actions, inappropriate behavior during services, or failure meet parent participation expectations.

Possible Risks Associated with Treatment

Like many things in life, therapy/behavioral treatment has inherent risks. Some of these risks are:

- Disruptions in your daily life that can occur because of therapeutic changes
- No promises can be made regarding learner progress. Some individuals progress and learn skills quickly, while other learns take longer to learn skills or experience difficulty retaining skills once learned
- Emotional pain due to exploring personal issues and family history
- Emotional pain due to tolerating your child's reaction to behavioral intervention
- Initial increases in the duration, frequency, or intensity of problem behaviors due to the "Extinction Burst"
- Although treatment begins with the hope of behavioral improvement and positive outcomes in the overall family functioning, there is no guarantee that this will occur. There is, however, a better chance of improvement occurring if all caregivers in the household participate in the therapy.
- Across studies, a small percentage of individuals receiving ABA treatment show relatively little improvement. More research is needed to determine why some individuals respond more favorably than others. Currently it remains difficult to predict the extent to which an individual will benefit from ABA treatment

Possible Benefits Associated with Treatment

Multiple studies across decades of time have contributed to the current understanding of the benefits of Applied Behavior Analysis:

- Improvements in communication, social relationships, play, self-care, school, and employment
- Increased participation in family and community activities



Child's Name _____

- Improvements in “school readiness”
- Significant improvements (socially valid improvements) in learning, reasoning, and adaptability to change
- Studies have demonstrated that there is no age or diagnosis for which ABA services have no potential benefit, however it is well established that ABA treatment is most impactful for young children (1-4), and when delivered intensively (25-40 hours a week). Individuals who receive intensive ABA treatment make larger improvements in more skill areas than do individuals who participate in other (non-ABA) interventions.

Your signature below will verify that you have read all of the information contained in this Informed Consent and that you asked questions about anything you have not understood up to this point.

By signing, you freely acknowledge your willingness to undergo treatment using Behavioral Therapy methods:

I acknowledge that Therapy involves potential physical, emotional, and mental risks, including but not limited to the potential for property damage, personal injury, and emotional duress. I acknowledge that proper implementation of Applied Behavior Analysis requires ongoing training and support from a Certified Behavior Analyst, adherence to the treatment plan, and diligence in data collection.

Name of Individual Receiving Treatment: _____

Signature of Parent/Guardian: _____ Date: _____