Learn. Communicate. Engage

Therapy Pre-Enrollment

Thank you for taking the time to complete this form. Your child's information will be added to our database. Our front-office administrator will be in contact with you to verify receipt of the document and gather any additional information that may be needed. Please fax this form to 763-328-2782 or email intake@autismmatters.net
If you have any questions, please contact your location of interest.

Personal Information:

Have you received services from us in the past? ❑ Yes ❑ No

Child's first and last name:_____ Preferred Language: _____

Do you need an interpreter?: ❑ Yes ❑ No Date of Birth:_____

Gender: ❑ Male ❑ Female

Mailing address: _____

Legal Guardian 1

Name: _____ Relationship to Child:_____

Phone: _____ Email: _____

Legal Guardian 2

Name: _____ Relationship to Child:_____

Phone: _____ Email: _____

Insurance information:

Primary Insurance name: _____ Secondary Insurance name:_____

Primary insurance ID # on card: _____ Primary insurance group #: _____

Secondary insurance ID # on card: _____ Secondary insurance group #: _____

Effective Date: _____

Marketing and Referral Information:

How did you hear about us? _____

Referral Doctor/Physician: _____

Primary Care Provider: _____

Service Information:

What location(s) is preferred?

❑ Baxter ❑ Cambridge ❑ Plymouth ❑ Rogers

INTERNAL USE ONLY: Date Paperwork Received: _____

What services are you interested in receiving? (check all that apply)

- ❑ ABA Therapy
- ❑ Speech-Language Therapy
- ❑ Occupational Therapy
- ❑ Feeding Therapy
- ❑ Psychotherapy

If seeking ABA Therapy, would you be interested in beginning Outpatient Services prior to ABA, if possible?

- ❑ Yes
- ❑ No

Date & type (DA/CMDE) of last assessment, if applicable: _____

Current services if applicable:

- ❑ ABA Therapy
- ❑ Speech-Language Therapy
- ❑ Occupational Therapy
- ❑ Feeding Therapy
- ❑ Psychotherapy
- ❑ Other: _____

List 3 of your child's favorite items:

_____

What domains does your child face difficulties in?

- ❑ Communication
- ❑ Daily Living Skills
- ❑ Maladaptive Behaviors
- ❑ Safety
- ❑ Eating/Feeding
- ❑ Play
- ❑ Relationships
- ❑ Gross Motor
- ❑ Fine Motor
- ❑ Sensory
- ❑ Other: _____

Availability:

To assist us in ensuring that we can provide the level of intensity that your child requires, as determined through assessment, please provide us with a schedule below of your child's availability for services.

Days of week:	Times of Day available (please document all times your child is available for services)	Times of day my child is NOT available for services.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

INTERNAL USE ONLY: Date Paperwork Received: _____