



Therapy Pre-Enrollment Form

Thank you for taking the time to complete this form. This information will be uploaded to our electronic 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

Preferred Language: _____ Do you need an interpreter? Yes No

First and last name: _____ Date of Birth: _____

Mailing address: _____

Email Address: _____ Phone: _____

Gender: Male Female Other: _____ Preferred Pronouns: _____

Legal Guardian 1 (Only required for client's under the age of 18)

Name: _____ Relationship to child: _____

Phone: _____ Email: _____

Preferred Communication Method: Email Phone

Legal Guardian 2

Name: _____ Relationship to child: _____

Phone: _____ Email: _____

Preferred Communication Method: Email Phone

Insurance Information

First and last name of primary subscriber: _____ DOB of primary subscriber: _____

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

Primary insurance group #: _____ Effective Date: _____

First and last name of subscriber on secondary insurance: _____

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

Secondary insurance group #: _____ Effective Date: _____

Marketing and Referral Information

How did you hear about us? _____

Referring Doctor/Physician: _____

Phone number: _____ Fax number: _____

Mailing address: _____

Primary Care Provider: _____

Phone number: _____ Fax number: _____

Mailing address: _____

Service Information

What location(s) is preferred?

- Rogers Cambridge Baxter Plymouth

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

- ABA Therapy Speech-Language Therapy Occupational Therapy
 Feeding Therapy Psychotherapy – Family Psychotherapy – Individual

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

- Yes No

Diagnostic Assessment (DA) completed? Yes No Date completed: _____

Date of last Comprehensive Multi-Disciplinary Evaluation (CMDE), if applicable: _____

Current services if applicable:

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

List 3 of your most preferred items:

What domains do you and/or your child face difficulties in?

- Communication Daily Living Skills Maladaptive Behaviors (attention, aggression, etc)
 Relationships Gross Motor Fine Motor Eating/Feeding
 Sensory Safety Emotional Regulation Play Other: _____

Availability

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

Week Days	Time of Day Available (document all times available)	Time of Day Not Available for Services
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		