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 Intake Coordinator will be in contact with you to verify receipt of the document and gather any other information that may be needed. Please send this form to intake@autismmatters.net.
If you have any questions, you may contact our Intake Coordinator at 952-544-0349.

Child's Name:_____
Date of Birth:_____ Gender: ❑ Male ❑ Female

Primary Insurance: _____ Secondary Insurance: _____

Primary Physician: _____

Legal Guardian 1

Name: _____ Relationship to Child:_____

Phone: _____ Email: _____

Legal Guardian 2

Name: _____ Relationship to Child:_____

Phone: _____ Email: _____

What location(s) is preferred?

❑ Baxter ❑ Cambridge ❑ Plymouth ❑ Rogers

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: _____
Who made a referral for services: _____

Current services:

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

Languages spoken in the home: _____

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: _____

INTERNAL USE ONLY: Date Paperwork Received: _____