New Client Questionnaire

Please complete the information below. NOTE: Not all questions apply to your child. An initial intake will only be scheduled AFTER we have received this questionnaire via Fax, U.S. Mail or Direct Delivery to our office. Please see attached information regarding services.

A.

Child's Name *(Last, First, M.I.):*	M ☐ F ☐	**DOB:**
Referred by:		
Parent Name 1:	**Parent Name 2:**	
Primary Address		
Primary Phone number:	Home _____ Cell _____ Can I leave detailed messages at the above contact numbers? YES ☐ NO ☐	
In case of emergency contact:	Name of emergency contact _____ phone _____	

B.

	Therapy/Service	Provider Name
Please check all the services your child currently receives:	☐Speech Therapy: /week minute ☐Occupational Therapy /week minute ☐Physical Therapy /week minute ☐Other: ☐ School/Grade: Current IEP: ☐YES ☐NO ☐ABA Services in the past ☐YES ☐NO	

C.

PRIMARY INSURANCE INFORMATION (Please submit the front and back of your current insurance card with this form if you will be using your insurance)

Policy subscriber's name (if not patient):	Policy subscriber's DOB (if not patient):	
Name of Primary Insurance:	Primary Insurance Address:	Insurance Phone number:
Patient's relation to subscriber: ☐self ☐ spouse ☐ child ☐ other		
Patient Subscriber ID : Two-digit number if multiple members on the policy:	Group Number	Employer

Phone: (704) 277-7018
Fax : 1-888-965-0596
Mail: 1020 Crews Rd STE M Matthews, NC 28105
Email: Katrina@JBSNC.com

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D.

Current Behavioral Concerns. Check ALL that apply:

Aggression (e.g. hitting, kicking, biting, scratching, pinching, hair pulling, head butting)	☐
Self-Injurious Behavior (e.g. biting self, scratching self, hitting self, pinching self, head banging self)	☐
Toileting (e.g. urination and/or defecation outside the toilet)	☐
Unsafe Behavior (e.g. running into the street, running out of the house, attempting to exit a moving vehicle)	☐
Pica (e.g. consuming or attempting to consume non-nutritive substance objects (does not include mouthing objects)	☐
Disruptive Behavior (e.g. frequent and loud yelling, verbal refusal, swiping or throwing objects)	☐
Property Destruction (e.g ripping, kicking, shattering, or otherwise devaluing property)	☐
Other: (Describe)	☐

How does your child communicate? Check ALL that apply:

Pointing/Gesturing	☐	1 or 2 signs (Sign language)	☐
Leading another with hand	☐	3 or more signs	☐
Standing next to what they want	☐	Augmentative communication device	☐
Whining	☐	1 to 2 words	☐
1 to 3 pictures (Picture Exchange Communication)	☐	2 to 4 phrases	☐
4 or more pictures (Picture Exchange Communication	☐	Complete, easily understandable sentences	☐

Current areas you would like to address in therapy. Please rate the following topics according to priority:

1 None	**2 Low**	**3 Neutral**	**4 Moderate**	**5 High**

Problem Behaviors					
Problem behavior (any form)	1	2	3	4	5
Self-injurious	1	2	3	4	5
Communication and Social Skills					
Functional communication with adults	1	2	3	4	5
Functional communication with peers	1	2	3	4	5
Conversational Skills	1	2	3	4	5
Social skills with peers	1	2	3	4	5
Play Skills	1	2	3	4	5
Attending/Academic Skills					
Impulsivity/hyperactivity	1	2	3	4	5
Attending during routine demands/Homework	1	2	3	4	5
Self-help Skills					
Toileting	1	2	3	4	5
Eating	1	2	3	4	5
Dressing	1	2	3	4	5

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Overview of Therapy:

1. Therapy focuses primarily on promoting functional language development, increasing social skills, and minimizing problem behavior. In my therapeutic approach, I believe that behaviors are learned and focus on identifying consequences in the environment that maintain problem behavior. I develop very specific definitions of behaviors I want to increase or decrease and I will frequently ask your input as to "what the behavior looks like?" With your input, I can help you determine what is maintaining a behavior, teach you to change the environment to prevent behaviors, teach more appropriate replacement behaviors, and then develop a plan to teach those behaviors. I can also develop a plan to help you improve your skills in working with your child. Some of the time I will be working with the client directly and at other times I may be training significant others.

2. I will develop and review the treatment plan with you and ask that you sign the plan indicating that you understand and agree to the plan. Working with clients individually is more effective when parents and family partner with the client and therapist in the therapeutic process. One of the most unique aspects of treatment is that decisions are made based on objective data during the course of therapy. Interventions will be data driven and I will be showing you data as part of my ongoing evaluation of treatment. I will take baseline data to first determine the nature and extent of the target behaviors. Following direct observation and data collection, I will develop and continue to collect data to determine if it is effective. I may also request that you, family members, or other individuals who come in contact with your child collect a variety of data during the course of therapy.

3. Therapy may be conducted in office, home, or community settings, depending upon the needs of the child and prior approval if pursuing services via third party insurance.

5. Consistency is the most crucial component of therapy and inconsistencies may adversely affect your child's progress. Thus a great deal of work is required. If at any point in time it is determined that you or others who come into contact with your child are engaging in behaviors that are counterproductive to therapy, this will be discussed this with you directly.

6. Therapy involves a significant amount of time and work to be effective. It can be a slow process, so immediate results are not always obtained. With treatment, it is important to know behaviors may sometimes worsen before they improve. It often takes months for significant improvement to occur. However, with consistency, effective teaching procedures, and motivation, you can help your child make significant changes.

7. Therapy is not meant to continue indefinitely. The goal is to provide the family with useful skills so that they can begin to implement these new skills in order to help their child. The therapist will periodically evaluate your progress towards fading services.

8. Additional referral sources will be provided if the family and/or provider determine that this type of therapy is not a good fit for your child and family.

NOTE: Please see the Consent to Treatment form for additional information regarding services and policies & procedures.

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