



1110 – 6900 Graybar Road Richmond BC V6W0A5 Tel. 604 232 4122 www.abacentre.ca

INTAKE APPLICATION (SCHOOL-AGE)

STUDENT INFORMATION	PARENT INFORMATION
Name (First/Last): _____	Mother's Name (First/Last): _____
Date of Birth: _____	Father's Name (First/Last): _____
Home Address (including Postal code) _____ _____	Guardians' Name (if not the parents): _____ _____
STUDENT'S MEDICAL INFORMATION	CONTACT INFORMATION
Primary Medical Diagnosis _____	Students' Phone Number(s) (home/cell): _____
Secondary Medical Diagnosis (if any): _____	Students' Email Address: _____
Age of Diagnosis _____	Mother's Phone number(s) (home/work/cell): _____
Diagnosed by whom: _____	Mother's Email Address: _____
Current Medication(s): _____	Father's Phone Number(s) (home/work/cell): _____
Previous Medication(s): _____	Father's Email Address: _____
Allergies (if any): _____	Guardians' Phone Number(s) (home/work/cell): _____
Special Diet (if any): _____	Guardians' Email Address: _____
Other Biological Intervention(s) used (if any): _____	

Personal Information
Siblings' names and ages (if any): _____
Who lives with the student? _____
Are there any cultural preferences you would like us to know about or take into consideration? _____
What is the primary language spoken at home? What other languages are spoken at home? _____
Does the student have any medical conditions or a history of medical conditions? If yes please describe. _____



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Do you have any concerns regarding the students hearing? Does the student have a history of ear infections? Has the students hearing been tested?
Do you have any concerns regarding the student's vision? Has the student been tested?
History of Intervention
What services is the student currently receiving?
What other service has the student received in the past (OT, SLP, Physio)? When?
Has the student ever had a curriculum based assessment (e.g. Early Start Denver, ABLLS-R, AFLS, VB MAPP)?
Has the student ever received ABA support in the past? If so please list a) type of program, b) past or current consultant, c) dates started and completed and overall impressions of the program.
Educational Information
What school does the student currently attend? (Name of school, Address, Phone Number)
What grade is the student in? Does the student have an IEP (Individualized Education Plan) at school?
Does the student receive support at school? If so how many hours per week is he/she support by an E.A.?
How many days per week does the student attend school? Full or partial day? If partial how many hours?
Social and Emotional Information
What opportunities does the student have to interact with peers? Does the student have friends?
How does the student adapt to new environments? Can the student go to public places?
How does the student adapt to new routines or changes in routines?
Is the student toilet trained? Go independently to the toilet? Do the routine independently (wipe, wash hands).
Is the student a picky eater? How many different foods might the student eat (estimate)?
Does the student have significant sleep issues? If yes please describe.
Can the student accept being told "no" to an item or activity? If not please describe the behaviour.
Please list up to three main goals for the student over the next year:
List documentation attached: Please provide a Diagnostic Report and school IEP if available