ABX Solutions, LLC

Child's Information

Child's Name: _____

Date of Birth: _____

Parent(s): _____

Siblings: _____

_____

Address: _____

_____

Phone: _____

Emergency Contact: _____

Insurance Information:

Insurance Provider: _____

Policy Number: _____

Effective Date: _____

Co-Pay: _____

Please provide a copy of your insurance card if we will be billing your insurance provider.

Diagnosis:

My Child Was Diagnosed With: ___ Autism ___ PDD-NOS ___ Asperger's Disorder

Approximate Date of Diagnosis: _____

Diagnosis Given By: _____

Other Co-Morbid Diagnoses: _____

_____

Therapy History:

My Child Presently Receives:

___ Speech Therapy at school/home/clinic (please circle)

___ hours per week

Therapist's Name: _____

Therapist's Phone: _____

___ Occupational Therapy at school/home/clinic (please circle)

___ hours per week

Therapist's Name: _____

Therapist's Phone: _____

___ Physical Therapy at school/home/clinic (please circle)

___ hours per week

Therapist's Name: _____

Therapist's Phone: _____

___ Early Intervention Services at school/home (please circle)

___ ABA Therapy at school

___ hours per week

Therapist's Name: _____

Therapist's Phone: _____

___ Other Therapies: _____

Please provide information on any additional therapies, i.e, auditory integration, horseback riding:

_____

_____

_____

School Placement:

My Child Attends: _____

Grade: _____

Type of Class: ___ Regular ___ Special_____ Resource _____

Teacher: _____

Birth History:

Was S/he Born at Full-Term? Yes No

Birth Weight: _____

Vaginal or Cesarean Birth? _____

Please describe any pregnancy or birth complications:

_____

_____

_____

_____

Medical History:

Pediatrician name: _____

History of Ear Infections (more than 2)? Yes No

PE Tubes? Yes No

History of ANY head injuries or loss of consciousness? Yes No

If yes, please describe: _____

Special Diet? Yes No

If yes, please describe: _____

Medical Condition(s)? Yes No

If yes, please describe: _____

_____

_____

Daily Medication(s)? Yes No

If yes, please describe: _____

_____

_____

Pediatrician's Name: _____

Pediatrician's Phone: _____

ABX Solutions, LLC

Child's Psychiatrist/Therapist Name:

_____

Psychiatrist/Therapist Phone: _____

Family History:

Please provide information relating to either parents known family history. This information is completely confidential.

Speech Problems (articulation, delayed speech, etc.)	Yes	No
Learning Problems (dyslexia, resource classes, etc.)	Yes	No
Autism	Yes	No
Mental Retardation	Yes	No
ADHD	Yes	No
Depression	Yes	No
Bipolar Disorder	Yes	No
Anxiety/Panic Disorder	Yes	No
Obsessive Compulsive Disorder	Yes	No
Schizophrenia	Yes	No
Psychiatric Hospitalization	Yes	No
Seizure Disorder	Yes	No

Concerns:

As parents, you know your child better than anyone. Please describe what the major areas of concern are at this time for your child:

_____

_____

_____

Goals:

What are your top 3 goals for your child over the next year:

ABX Solutions, LLC

Consent to Exchange Information:

I, _____, legal guardian of _____ hereby give consent for all records to be exchanged between ABX Solutions, LLC and the following individuals/companies:

Pediatrician: _____

Other Physician(s): _____

_____

School District: _____

Therapist(s): _____

_____

_____

This consent will expire 2 years from the date signed below. I understand that I can revoke this consent in writing at any time.

ABX Solutions, LLC
2340 Treescape Drive # 8, Charleston, SC 29414

Legal Guardian: _____

Date: _____