Autism Spectrum
Mandate Services

4 Mill Run Court
Medford, New Jersey 08055
www.autismservicesnj.org
609.953.5793

PATIENT INFORMATION

Patient Name: _____ Age: _____ (Circle one) Male Female

Developmental Diagnosis: _____

Diagnosed by Dr. _____ **Date:** _____

FAMILY INFORMATION

Primary Caregiver(s): _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____ (Circle preferred contact method)

Sibling: _____ Age: _____

Sibling: _____ Age: _____

Sibling: _____ Age: _____

Who resides with the patient?

_____

MEDICAL INFORMATION

Does the patient have any medical diagnoses? YES NO If yes, what is the diagnosis?

_____

Does the patient take any medications? YES NO If yes, complete the chart below.

Medication	Prescribed by	Reason (ailment)

Has the patient had any surgeries? YES NO If yes, describe below

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SCHOOL INFORMATION

Does the patient attend school? Yes No If yes, please respond below.

Type of Program: _____ Days/Times: _____

School Name and Location:

_____

What services does the patient presently receive in school?

Type of Service: _____ How Often: _____

Type of Service: _____ How Often: _____

Type of Service: _____ How Often: _____

Does the patient receive any other private services? YES NO If yes, describe below.

Type of Service	How Often	Funded by

Patient Availability:

When is the patient available for ABA services? (Please write times under each day of the week)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

State your reason(s) for initiating ABA services:

_____

_____

_____

What do you hope to achieve by receiving ABA services:

State the patient's strengths:

State the patient's challenges:

Write below the activities, items and foods that the patient enjoys the most. (Reinforcers)

Is there any other information you would like to share with us?