Sanger and Associates

BEHAVIORAL AND PSYCHOLOGICAL SERVICES

PATIENT PROFILE SHEET

DEMOGRAPHIC INFORMATION

Name: _____ Medicaid#:_____

DOB: _____ Sex: _____ Phone: _____

Address: _____

City: _____ State: _____ Email: _____

Parent/Guardian's Name(s): _____

Address (if different from patient): _____

_____

Home phone: _____ Cell phone: _____ Alternate phone: _____

School (if attends): _____ Phone: _____

Teacher at school: _____

REFERRAL INFORMATION

Referring Physician/Person referring patient for services: _____

Diagnosis: _____

Reason for Referral: _____

_____

_____

Is client verbal? _____ If so, what language? _____

Pediatrician/Family Doctor: _____ Phone: _____

SCHEDULE DESIRED

Please list the times you are available for behavior services on each day. If you are not available on a day 'X' it out.

Monday	Tuesday	Wednesday	Thursday	Friday	Weekends

BEHAVIOR INFORMATION

Please list behavior problems you are concerned about (tantrums, aggression, etc.) as well as how often the behavior is occurring.

Problem Behaviors	**1.**	**2.**	**3.**	**4.**
Description of behavior				
How often behavior is occurring				

Please list skill deficits you are concerned about (language, fine motor, potty training, etc.) that you would like to see addressed in therapy.

Skill Deficits	**1.**	**2.**	**3.**	**4.**
Description of deficit				

FORMS OF COMMUNICATION

Is child vocal? _____ If so, does he/she have delays with communication? _____

If there are delays, approximately how many words does he/she use? _____

Does he/she use sentences? _____

Does he/she request things using words? _____

Does he/she request things using signs or pictures? _____

If there is not form of communication at home (vocal language, signs, or pictures) how does your son or daughter request items he/she wants? _____

_____

ADDITIONAL INFORMATION

Please list any additional information you would like to share with us regarding your child at this time. _____

_____

_____

NECESSARY INFORMATION –

For MEDICAID/MEDIPASS patients:

What type of Medicaid:_____

Parents: You must have your child's referring physician provide you with a referral for ABA therapy with a diagnosis on the referral. You also must have either an IEP or an Evaluation from a Developmental Pediatrician.

Please fax this information to 863-583-0840

Once this information is received we will contact you regarding availability.