Spectrum of Grace, LLC
4425 Plano Pkwy Suite 403
Carrollton, TX 75010

Client Registration Forms

Client Information:

Client Name: _____

Address: _____

Social Security No: _____

Gender: ☐ M ☐ F Date of Birth: _____

Parent/Guardian Information:

Mother's Name: _____
Address:_____
Date of Birth: _____ Phone number (Home, Cell, Work):_____Occupation:_____
Insurance Carrier:_____ Policy Number: _____
Security No.: _____ _____
Email:_____ Employer: _____
Group Number: _____

____ Primary Coverage ____ Secondary Coverage

Father's Name:_____
Address:_____
Date of Birth: _____ Phone number (Home, Cell, Work):_____Occupation:_____
Insurance Carrier:_____ Policy Number: _____
Social Security No.: _____ _____
Email:_____ Employer: _____
Group Number: _____

____ Primary Coverage ____ Secondary Coverage

Other Insurance Coverage:

Policy Holder: _____Insurance Carrier: _____ Insurance Policy No.: _____Insurance Group No.: _____

Siblings/Household Members (Other than parent/guardian)

Name: _____
Date of Birth: _____ Relationship: _____

Name: _____
Date of Birth: _____ Relationship: _____

Name: _____
Date of Birth: _____ Relationship: _____

Name: _____
Date of Birth: _____ Relationship: _____

Emergency Contact Information

Name: _____ Phone Number: _____
Relationship to Child: _____
Name: _____ Phone Number: _____
Relationship to Child: _____

Other Services Provided (Speech/PT/OT, etc.):

Name of Provider: _____ Services Provided/Times per week: _____

Name of Provider: _____ Services Provided/Times per week: _____

Name of Provider: _____Services Provided/Times per week: _____

Diagnosis:

Primary Diagnosis 1: _____

Diagnosis Date(s): _____Diagnosing Professional: _____

Primary Diagnosis 2:

Diagnosis Date(s): _____
Diagnosing Professional: _____

Medical Conditions (if any):
_____
_____

Allergies: _____Diagnosing Professional: _____

Special Diet Information: _____

Current Medications

Medication	Dosage	Frequency

Available Service Times Requested:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
					[redacted]	

What are your goals and/or expectations for the services requested?

_____

_____

_____

Problem Behavior Information:

Behavior (please describe)	**Frequency (hourly, daily, weekly, occasionally, more often, less often)**	**Duration (how long does the behavior occur)**	**Severity-Mild (disruptive, little risk), Moderate (property damage/minor injury), Severe (significant threat to health/safety**

What situations are these behaviors MOST likely to occur? (Days/times/settings/activities/persons present)

_____

_____

_____

_____

What situations are these behaviors LEAST likely to occur? (Days/times/settings/activities/persons present)

_____

_____

_____

_____

What typically happens right BEFORE problem behavior occurs?

_____
_____
_____
_____

What typically happens right AFTER problem behavior occurs?

_____
_____
_____
_____

What current treatments are being implemented?

_____
_____
_____
_____

What treatments have been implemented in the past?

_____
_____
_____
_____

What motivates/interests your child?

_____
_____
_____
_____

Please list any other important information you would like us to know about your child.

_____
_____
_____
_____

Behavioral Language Assessment Expressive Verbal Skills

Describe your child's ability to babble speech sounds:

_____
_____
_____

Describe your child's spontaneous language:

_____
_____
_____

Describe how your child indicates what he/she wants:

_____
_____
_____

Describe the type and number of items that your child asks for:

_____
_____
_____

Describe your child's ability to imitate vocal sounds, words, phrases:

_____
_____
_____

Describe your child's ability to label items, events, or actions (spontaneous? how many? how often?):

_____

_____

_____

Describe your child's ability to answer questions:

_____

_____

_____

Receptive Language Skills

Describe your child's ability to follow directions and routines within context or with model:

_____

_____

_____

Describe your child's ability to follow directions and routines out of context or without a model:

_____

_____

_____

How many items is your child able to identify receptively? _____

Is your child able to select an item from a field of two or more when given a description of the item?

_____

Motor Imitation

Is your child able to imitate simple motor movements such as clapping, waving? Y☐ N☐

Is your child able to imitate actions using objects---using "do this" with a model? Y☐ N☐

Your child makes eye contact with (circle all that apply):

☐ Mom ☐ Dad ☐ Siblings ☐ Familiar people ☐ Others

Describe your child's response when addressed by others:

_____
_____
_____

Describe your child's interest in doing what others are doing:

_____
_____
_____

Describe your child's ability to participate in turn-taking activities:

_____
_____
_____

Is your child conversational? Y N Describe:

_____
_____
_____

Does he/she get "stuck" on certain topics? Y N Describe:

_____
_____
_____

Play Skills

Describe your child's play with toys (identify the toys and length of time involved):

_____
_____
_____

Does your child use the toys as intended or as self-stimulatory objects?

_____

Describe your child's interactive play with other children:

_____

_____

_____

Describe your child's imaginative and pretend play skills:

_____

_____

_____

Self-help Skills

Describe how your child feeds him/herself:

_____

_____

_____

Is your child toilet trained completely? Y N

If not, what program did you use or have your tried with your child?

_____

_____

_____

Does your child dress independently: Y N Describe:

_____

_____

_____

Describe any household tasks that your child assists with:

_____

_____

_____

Describe how your child responds to situations of danger:

_____

_____

_____

Child's Educational Background:

School: _____ Grade: _____

☐ Home School ☐ Life Skills. ☐ Emotional Support

☐ General Education ☐ Autistic Support ☐ Learning Support

☐ Private School ☐ Speech/Language

Contact Name: _____ Phone Number: _____

Please attach the most recent copy of your child's IEP, RR, ETR, FBA and/or BIP.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Spectrum of Grace, LLC. I understand that I am financially responsible for any balance. I also authorize Spectrum of Grace, LLC or insurance company to release any information required to process my claims and to establish service eligibility/authorizations.

Client's Name: _____ DOB: _____

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____