K O R A Analysis, Inc.
ABA Consultation + Treatment

(phone) 703.675.7465
(fax) 888-548-0846
www.aba-consult.com

CLIENT INTAKE FORM

This form is to be completed by the Parent/Guardian/Caregiver/Case Manager of a prospective client of KORA Analysis, LLC prior to an initial consultation visit.

CLIENT INFORMATION

Full Name	
Gender	☐ Male ☐ Female ☐ Other _____ ☐ Prefer not to say
Preferred Pronoun	☐ He ☐ She ☐ They ☐ Other _____
Date of Birth	
Primary Home Address	
SSN	
School Grade, if applicable	

FAMILY INFORMATION

Individual #1 Full Name	
Gender	☐ Male ☐ Female ☐ Other _____ ☐ Prefer not to say
Preferred Pronoun	☐ He ☐ She ☐ They ☐ Other _____
Preferred Phone Number	
Primary Home Address	
Email Address	
Relationship to Client	

Individual #2 Full Name	
Gender	☐ Male ☐ Female ☐ Other _____ ☐ Prefer not to say
Preferred Pronoun	☐ He ☐ She ☐ They ☐ Other _____
Preferred Phone Number	
Primary Home Address	

Kristin Frigelj, M.S., BCBA, LBA, Director
kristin@aba-consult.com

Amanda Boettcher, M.Ed., BCBA, LBA, NoVA Intake Coordinator
amanda@aba-consult.com

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Email Address	
Relationship to Client	

INSURANCE INFORMATION

Please provide a copy of insurance card at the start of services.

My insurance covers	☐ ABA therapy ☐ Does not cover ABA therapy ☐ Therapeutic Consultation ☐ I do not know if I have coverage
Insurance Carrier	
Name of Policy Holder	
SSN of Policy Holder	
DOB of Policy Holder	
Address of Policy Holder	
Member ID #	
Group #	
Medicaid #	

Need for Services
Check all that apply:

☐ Physical aggression to others
☐ Physical aggression to self
☐ Property destruction
☐ Elopement
☐ Self-care skills need
☐ Communication skills need
☐ Other: _____

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SERVICE AVAILABILITY

Client and/or Caregivers are available for services at the following times (approximately):

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

DEVELOPMENTAL/MEDICAL HISTORY

Diagnosis	At Age

Toilet Trained: ☐YES ☐NO If no, assistance required: _____

If no but previously attempted, please describe efforts:

_____

_____

Medications:

Current - ☐ No Medications at this time

Name	Dosage	Administration Times	Used For

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Historical - ☐ No previous medications

Name	Dosage	Administration Times	Used For

TREATMENT HISTORY:

Service Provided	Begin/End Dates	Reason for Discontinuation

Has the client ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations?

☐ Yes ☐ No If yes, please explain treatment and results.

_____

_____

_____

Are there any medical conditions that need to be considered when delivering behavioral treatment?

☐ Yes ☐ No If yes, please explain.

_____

_____

_____

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SCHOOL/PROGRAM INFORMATION

Does the client attend school or a day placement program? ☐ Yes ☐ No

School/Program Name	
Contact Name	
Telephone	
Email	
Hours/Days in Attendance	
IEP?	☐ Yes ☐ No ☐ Copy provided
Can services be provided at this placement?	☐ Yes ☐ No

I hereby acknowledge that the information contained in this application is accurate in all respects.

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

OR

_____ _____
Support Coordinator Printed Name Date

_____
Support Coordinator Signature

Thank you for expressing interest in receiving behavior services from KORA Analysis - we will be in touch to let you know of our current availability!

Please email this form to:
Hampton Roads Virginia:
kristin@aba-consult.com

Northern VA/DC/Maryland:
amanda@aba-consult.com

Or fax to: 888-548-0846

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