Family First
ABA Therapy

Client Registration Form

Welcome!

Thank you for your interest in receiving services from Family First ABA Therapy Inc. This registration form will provide the information needed to begin the process of assessing your child's needs and what level of support your family requires.

Family First ABA Therapy offers several therapy options for families to support the diverse needs of the individuals and families we serve. Prior to scheduling a meeting to discuss beginning services, please take a moment to review the options listed below and decide which one you may be interested in.

Our Services:

Family First ABA Therapy Inc. provides evidence-based treatment founded on the principles of applied behaviour analysis (ABA) to support the development of skills and minimize challenging or interfering behaviours. All service options include an ABA approach while providing supportive and enriching experiences for the families we work with.

Focused ABA Services: This service is recommended for individuals with one to two areas of need that can be worked on less intensely. Examples include developing functional play or social skills and decreasing problem behaviours. The Behaviour Consultant will meet with the parent/caregiver and child on a weekly basis for 3 to 6 hours.

Comprehensive ABA Services: This service is more intensive than the focused services and will target multiple domains of development. Examples include developing language and communication skills, reducing maladaptive behaviours, and toilet training. The Behaviour Consultant will meet with the parent/caregiver and child on a weekly basis for 15 to 40 hours.

What to Expect:

Once this registration form is complete, please email your form to familyfirstaba@gmail.com. Please be thorough in your responses. After reviewing your registration information, you will receive a call to obtain any additional information and schedule a meeting to begin the assessment process. All our services follow the model outlined below. This process will ensure that a personalized intervention plan is developed that meets the needs of the child and family. The plan will be reviewed with the parent/caregiver and once approved, will be implemented. After 6 months, the plan will be reviewed, and an updated assessment provided to measure progress and determine next steps.

I look forward to working with you and your family!

Sincerely,

Ashley Winter

Family First ABA Therapy

Client Registration Form

General Information:

Name of person completing this form: _____

Relationship to the client: ☐ Parent ☐ Guardian ☐ Other: _____

Client's Legal Name: _____

Date of Birth: _____

Age: _____

Gender: ☐ Male ☐ Female ☐ Unspecified

Home Address: _____
(Address) (City/Province) (Postal Code)

Family Information

Parent/Caregiver 1

Name: _____

Relationship to client: _____

Address (if different from above): _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Parent/Caregiver 2

Name: _____

Relationship to client: _____

Address (if different from above): _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

If there are other siblings in the home, please list their names and ages:

_____

Primary language of client: ☐ English ☐ Other (specify): _____

Previous/Additional Services and Education

Has the client received any services from other ABA providers or other professionals such as an Occupational Therapist, Speech and Language Pathologist, Psychologist, Psychiatrist, or other mental health professionals?

☐ Yes ☐ No ☐ Unknown

If yes, please list services that have been accessed (include names of the professional or organization and the type of service that was provided):

Does the client currently attend childcare, a school, or another educational institution?

☐ Yes ☐ No

If yes, please provide details about the care the client is receiving and any support that the child receives (supported by an Educational Assistant, fully integrated into the classroom, attending school full- or part-time):

Medical Information

List any diagnoses or medical conditions:

Allergies:

_____

List any medications that the client routinely takes:

How would you describe the client's sleep routine?

Does the client require support with washroom routines?
☐ Yes ☐ No

Concerns

Please describe the reasons for seeking ABA services for the client. This may include, but is not limited to, sensitivities, maladaptive or problem behaviours, play skills, communication, and social skills.

Please list client strengths:

Please list your top three goals for ABA:

1. _____
2. _____
3. _____

Are you willing to actively participate in services? ☐ Yes ☐ No

Funding

☐ Yes ☐ No (private)

If yes, please indicate the source of funding (Insurance, Ontario Autism Program, etc.)

Availability

Please mark on the table below the times you and the client are available for services.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00am					
9:00am					
10:00am					
11:00am					
12:00pm					
1:00pm					
2:00pm					
3:00pm					
4:00pm					

Signature and Acknowledgement

By signing, I hereby acknowledge that all information contained in this application will become part of the client's clinical file and the information provided is accurate.

_____ _____

Signature of Parent/Guardian Date