

Mid-Step Services, Inc.

**Pier Center for Autism**

3895 Stadium Drive

Sioux City, IA 51106

712.522.2961

www.piercenter.org

Dear Prospective Client,

Thank you for your interest in the Pier Center for Autism. Please complete the Client Registration Form so we have sufficient information to assess how we can be of service. With this document, we will assess an appropriate path towards beginning individual services.

Once you have completed the documents, you can mail them, together with a copy of your insurance card(s), front and back, to the above address. Please also include copies of any relevant medical records, such as diagnosis paperwork. You can also scan and email all documents to our Operations Director, Jeremiah Gray, at [jgray@midstepservices.com](mailto:jgray@midstepservices.com). Please feel free to call us if you have any questions.

Thank you again for your interest in our services, and we look forward to working with you.

Sincerely,

The Pier Center for Autism

Client Registration Form

Today’s Date \_\_\_/\_\_\_/\_\_\_\_

Please complete the following information and return to the Pier Center along with copies of your insurance information (front and back of cards) and proof of diagnosis.

# Child Information

Child’s Name Date of Birth / / Age: Sex: M F

Street Address City/State/Zip

Primary Diagnosis Date of Diagnosis \_\_\_/\_\_\_/\_\_\_\_

Name of the Physician and Clinic who gave diagnosis

Do you have testing results/report from this physician? □ Yes *(Please be sure to turn in a copy to the clinic)*

Secondary Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis / /

Social/Family History of Mental Health or Intellectual/Developmental Disability (IDD)

# Family Information

Caregiver #1 Name Relationship to Child

Caregiver #1 Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Caregiver #1 Cell Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver #1 Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver #2 Name Relationship to Child

Caregiver #2 Street Address (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Caregiver #2 Cell Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver #2 Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings living at the same address as child (list names and ages)

Others living at the same address

Language(s) spoken in the home

# Medical Information

Child’s current height \_\_\_\_ft. \_\_\_\_in. Child’s current weight \_\_\_\_\_\_lbs.

Does your child have any allergies? □ Yes; please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No

Does your child take medication? □ Yes □ No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dosage | Frequency | Time of Day | Reason |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

If yes, please fill out the following chart:

# Speech and Language Development

Does your child babble? □ Yes □ No Age of first words? \_\_\_\_\_\_

Speech and language problem first noticed at what age? \_\_\_\_\_\_

How does your child most often communicate? □ Verbally □ Signs □ Pictures □ Electronic Device

□ Other; please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of your child’s speech is understood by other adults? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently receiving speech therapy? □ Yes; where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No

# Basic Developmental Information

At what age did the child sit alone? \_\_\_\_\_\_ crawl? \_\_\_\_\_\_ walk unassisted? \_\_\_\_\_\_\_

Is your child potty trained? □ Yes □ No □ In progress; please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child feed themselves? □ Yes □ No If yes, how? □ With hands □ With silverware □ Food-appropriate

How many different foods does your child eat? □ 1-5 □ 6-10 □ 11-15 □ 16-20 □ 21+

If fewer than 5, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child dress themselves? □ Yes, completely □ Yes, with assistance □ No, not at all

Which hand does your child use to eat? □ Left □ Right □ Either/both

# Therapies and Services

Please check other services that the child is *currently* receiving and list the number of hours per week. **Please enclose a copy of the child’s most recent IEP, and/or a copy of a recent ABLLS or VB-MAPP assessment if available.**

□ Early Intervention Services - Hours/week ­­­­­\_\_\_\_\_\_ □ Speech and/or Language Therapy - Hours/week \_\_\_\_\_\_\_

□ Occupational and/or Physical Therapy - Hours/week \_\_\_\_\_\_ □ ABA/Verbal Behavior Therapy - Hours/week \_\_\_\_\_\_

□ Feeding Therapy - Hours/Week \_\_\_\_\_\_\_\_ □ Other (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Behaviors

Please check any of the following behaviors that your child exhibits:

□ Screaming/crying/whining □ Throwing/breaking objects □ Self-injury

□ Aggression toward others □ Tantrums □ Elopement/running away

□ Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do these behaviors occur? □ Monthly □ Weekly □ A few days per week □ Daily □ Hourly or more

What typically happens before the behavior occurs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you respond to problem behavior? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Goals

What goals do you have for your child in the next 3-5 years?

1.

2.

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Schooling

Current School Teacher Grade

What is your child working on in school?

Does your child currently have an IEP? □ Yes □ No *(Please be sure to turn in a copy to the clinic)*

The child who benefits most from an ABA program is a child whose parents or caregivers are supportive of its methods and participate in its success by transferring techniques to the home environment.

Are you willing to work at home with your child?

□ Yes □ No; please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you able to attend parent meetings to discuss your child’s progress?

□ Yes □ No; please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to attend additional training opportunities with your child at the Pier Center?

□ Yes □ No; please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have additional caregivers who you feel would benefit from training with your child?

□ Yes; please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No

What are some things you would be most interested in learning during your trainings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tell us anything else that you would like us to know about your child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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CLIENT REGISTRATION FORM

Child’s Name: Date of Birth: / / Sex: M F

Full Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select funding sources you currently have:

□ Private Pay □ Medicaid □ Private Insurance □ Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_

**FINANCIALLY RESPONSIBLE PERSON**

Name: Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Address:

Home Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_

Employer Name: Employer Phone Number: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_

Employer Address:

**PRIMARY INSURANCE INFORMATION** *(Please include a copy of the front and back of your card)*

Plan Name: I.D. Number:

Address: Group Number:

Policy Holder: Effective Date:

Policy Holder’s Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Sex: M F Insured SS# \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_

**SECONDARY INSURANCE INFORMATION** *(Please include a copy of the front and back of your card)*

Plan Name: I.D. Number:

Address: Group Number:

Policy Holder: Effective Date:

Policy Holder’s Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Sex: M F Insured SS# \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_

The undersigned hereby acknowledges that the information contained in this application is accurate in all respects. I authorize the release of any medical information, by The Pier Center for Autism or its agents, in order to process medical claims with my insurance company. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I am financially responsible for payment, including any unpaid deductible, co-pay or co-insurance balances, or amounts not covered by my insurance policy.

Signature: Date: