New Client Registration

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 820-1919

Thank you for your interest in receiving services from Horizons Behaviour Consulting! To help in the first few steps of the intake process, below is some information about the services that we offer and the intake process.

Filling out the registration form provides us with all the information needed to start services. These forms will provide the behaviour consultants with important information about the client and as such, we require that the additional paperwork be turned in prior to scheduling services. Below we have provided a list of our services and brief descriptions of each to aid in deciding what services you may be interested in:

Applied Behavior Analysis (ABA) Services: Our behavior Consultants provide evidence-based treatment based on the principles of applied behavioral analysis (ABA), in order to identify individualized goals to support skill acquisition, to decrease the frequency of challenging behaviors, and to support the individual in a variety of settings. The types of services that are offered include:

- **Focused ABA Services:** The Behaviour Consultant will meet with the parent/caregiver and the client for 2 to 5 hours per week and work on a limited number of behavioural targets (e.g., problem behaviours, functional skills, social skills). Services can typically last anywhere between 4 to 6 months and can be offered through different online platforms if requested (e.g., Skype, Zoom).
- **Comprehensive ABA Services:** The Behaviour Consultant will meet with the parent/caregiver and the client for 25 to 40 hours per week and work on multiple affected developmental domains (e.g., communicative, social, maladaptive behaviours, etc.). Comprehensive services are more intensive than focused services and can typically last anywhere between 6 months to 2 years.

Please thoroughly fill out each page of the registration form that is provided below. Once you have completed the forms, please email it to info@horizonsbehaviourconsulting.com and I will be in contact with you when I receive the registration form to continue the intake process. If you have any questions along the way, please do not hesitate to contact me. We look forward to working with you and your family!

Sincerely,

Matt Derkach, M.ADS, BCBA
Behaviour Analyst
Horizons Behaviour Consulting
Contact: 613-820-1919
www.horizonsehaviourconsulting.com

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Person completing this form

Name: _____
Please indicate relationship to the client: ☐Parent ☐ Guardian ☐ Other: _____

Are you authorized to consent for this individual's healthcare?
_☐_ No _☐_ Yes

Client's personal information:

Legal Name		**Preferred Name**	
Gender	□ M □ F	**Date of Birth**	
Home Address			
School			

Family Information

Client lives with: _____

Parent/Guardian 1

Legal Name		**Preferred Name**	
Relationship	□ Mother □ Father □ Other; please specifiy		
Home Address			
Cell phone		**Home Phone**	
Email			
Employed by			
Occupation			

Parent/Guardian 2

Legal Name		**Preferred Name**	
Relationship	□ Mother □ Father □ Other; please specifiy		
Home Address			
Cell phone		**Home Phone**	
Email			
Employed by			
Occupation			

Names and ages of siblings, or additional information regarding others living with Client.

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Primary language of client: □ English □ Other: specify _____

Percent of time the client is exposed to non-English language(s):_____

Emergency Contact Information

Please provide the name and phone number of an individual who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: _____

Relationship: _____

Home Phone Number: _____

Cell Phone Number: _____

Previous/Additional Service Providers

Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselors?
☐ No ☐ Yes ☐ Unknown

If yes, please provide the following information:

Name		**Type of Specialist**	
Date service started		**Date service ended**	
Hours per week		**Length per session**	
Purpose of service			

Name		**Type of Specialist**	
Date service started		**Date service ended**	
Hours per week		**Length per session**	
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Name		**Type of Specialist**	
Date service started		**Date service ended**	
Hours per week		**Length per session**	
Purpose of service			

Medical Information

Hospital/Clinic Preference:_____

Client's Primary Doctor: _____

Doctor Phone Number: _____

Diagnoses		
Allergies	☐ Yes ☐ No	If yes, please specify:
Medications	☐ Yes ☐ No	If yes, please specify:
Dietary Needs	☐ Yes ☐ No	If yes, please specify:
Other restrictions we need to know about	☐ Yes ☐ No	If yes, please specify:

**An additional *Permission to Administer Medication* form will need to be completed and on file for each specific medication your client takes at Horizons Behaviour Consulting.

Client's Interests

Three preferences (favorite activities, food, topics, toys, sensory)	Three dislikes (things your client avoids or will not interact with
1	1
2	2
3	3
Other important information regarding interests	

Cultural Considerations

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to beginning services.

Funding

□ Yes □ No (private)

If yes, please indicate the source of funding (e.g., Ontario Autism Program, Clientren's Aid Society, Insurance, etc.) and the amount of funding you receive per year (e.g., $20,000 through OAP).

Hours of Availability

Please mark the times you and the client ARE available for services.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:30-11:30					
12:30-3:30					

Concerns

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Please answer the following questionnaire to the best of your ability.

Does the client engage in any of the following behaviours, if yes please specify	☐ Hitting	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
	☐ Biting	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
	☐ Tantrums	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
	☐ Breaking Objects	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
	☐ Self-Injurious Behaviour	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
	☐ Head Banging	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
	☐ Undressing in Public	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
	☐ Others	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
Please provide more information for any of the boxes you checked above		
Increase Skills	☐ Communication ☐ Academics ☐ Toileting ☐ Sleep ☐ Eating ☐ Personal space ☐ Social Skills ☐ Other _____	

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Please provide more information for any of the boxes you checked above		
Is the client toilet trained	☐ Yes ☐ No	
How well is the client able to follow vocal instructions?	☐ Able to follow two or more step instructions and only needs to be asked once. ☐ Able to follow one step instructions and only needs to be asked once. ☐ Needs assistance to follow instructions. ☐ When given an instruction they will engage in one of the behaviours from the first question (please specify)	
Does the client ever wander, leave a safe area, or caregiver without permission?	☐ Yes (please specify how often) _____ ☐ No	
Please select the options that best reflects the client's current speech abilities	☐ Able to communicate wants, needs, and maintain conversation in full clear sentences. ☐ Able to communicate needs in full sentences. ☐ Able to communicate needs with one or two words. ☐ Does not communicate using words	
Please indicate the level of support required for daily living skills (i.e. dressing, eating, brushing teeth)	☐ High level of support required ☐ Moderate level of support required ☐ No support required (indepdendent)	
Please select the skills that the client currently HAS:	☐ Shares toys with others. ☐ Plays with others. ☐ Asks for help. ☐ Asks for items/activities they want. ☐ Can imitate something after watching someone else do it.	☐ Can read words or sentences (specify) ☐ Can count up to: _____ ☐ Recognizes and identifies letters and numbers ☐ Recognizes and identifies common people or items

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SIGNATURE and ACKNOWLEDGEMENT

By signing, I hereby certify that the above statements are true and correct to the best of my knowledge and understand all information in this packet will become part of the patient's clinical file.

_____ _____

Signature (Parent/Guardian) Date

I hereby confirm that I have reviewed with the parent/guardian the information set forth in this document and understand all information in this packet will become part of the patient's clinical file.

_____ _____

Signature of BCBA Date

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CONSENT FOR COMMUNICATION

Horizons Behaviour Consulting would like to know your preferences by which we may contact you regarding your services.

I do not have a preference, Horizons Behaviour Consulting may contact me using either email or phone ☐ No ☐ Yes

I prefer the majority of all contact to take place via phone ☐ No ☐ Yes. If yes, please indicate below best contact number(s):

Home Number: _____ Best time(s) to call: _____

Is it ok to leave a message at this number? ☐ No ☐ Yes

Work Number: _____ Best time(s) to call: _____

Is it ok to leave a message at this number? ☐ No ☐ Yes

Cell Number: _____ Best time(s) to call: _____

Is it ok to leave a message at this number? ☐ No ☐ Yes

I prefer the majority of all contact to take place via email ☐ No ☐ Yes

If yes, please review and sign the consent for email below:

Staff working for Horizons Behaviour Consulting may communicate via email, but this agreement does not obligate staff at Horizons Behaviour Consulting to communicate via email. Email may be one of many forms of communication with staff at Horizons Behaviour Consulting.

Risk of using email

I want to use email to communicate to staff at Horizons Behaviour Consulting about my/the client's personal health care. I understand that staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may impact the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.

- Copies of email may exist after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and analyze emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread different computer viruses.
- Email delivery is not guaranteed.

Understanding the use of email, I give permission for staff at Horizons Behaviour Consulting to send me email messages that include my/the client's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the client, whenever necessary.

Email address:

_____

Client's name

_____

_____ _____

Signature (Parent/Guardian if under 18yrs old) Date

_____ _____

Signature of client (If client is 13yrs old or over) Date

Please send Registration Form to info@horizonsbehaviourconsulting.com once completed