Amanda Nicolson, Ph.D., BCBA-D
Private Assessment & Consultation

New Client Information Form

Child/Student Information:

Child/Student Name:

____
Last First Middle Initial

Date of Birth: ______________________ Age: __________

School: ______________________ Grade & Type of Classroom: __________

Parent/Guardian Information:

Name(s): ____

Relationship to Client: ____

Address: ____

Contact Number (s): ______________________ Alt: ______________________

Email Address: ____

Marital Status (circle): Single / Married / Divorced / Separated / Court Order

Check the box of service(s) desired:

□ Autism Assessment □ Consultation for Services/programs/therapy

□ Independent Education evaluation □ School Consultation/IEP Consultation

Primary Concern/Reason for Referral:

Family Background

Please include all individual who live in the home:			
Name	Relationship	Age	Notes

Referral Information

Referral Source: ______________________ Reason for Referral: _____________________________________

Are you a CVRC Client? ◻ Yes ◻ No

Previous Diagnostic Information:

Diagnosis: ____

Diagnostician: _________________________________ Date of Diagnosis: _________________

Diagnosis: ____

Diagnostician: _________________________________ Date of Diagnosis: _________________

Treatment Background

Treatment Received: ____

Treatment Provider: __________________________________ Duration of Service: ________________

Treatment Received: ____

Treatment Provider: __________________________________ Duration of Service: _______________

Medical and Medication History

Describe current medical concerns: ____

____

Current Medications:
Medication: ______________________ Duration: __________ Current? ______

Medication: ______________________ Duration: __________ Current? ______