



**Center for Children with Autism  
Application for Enrollment  
(Ph) 214.333.7076  
(Fax) 214.331.2486**

**I. IDENTIFYING INFORMATION**

\_\_\_\_\_  
**Child's Name**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City, State**

\_\_\_\_\_  
**ZipCode**

**Child lives with:**

**Mother & Father**

**Mother**

**Father**

**Other/Legal Guardian (please specify)** \_\_\_\_\_

**\*\*\* guardianship papers must accompany application**

**Primary language spoken in the home:** \_\_\_\_\_

**Parent/ Guardian's Name:** \_\_\_\_\_

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Work Phone**

\_\_\_\_\_  
**Cell Phone/Emergency Number**

\_\_\_\_\_  
**Email Address**

\_\_\_\_\_  
**Name and address of alternate/emergency contact**

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Work Phone**

\_\_\_\_\_  
**Cell Phone/Emergency Number**

\_\_\_\_\_  
**Email Address**

**List other children in family:**

<b>Name</b>	<b>Age</b>	<b>Name</b>	<b>Age</b>
_____	_____	_____	_____
_____	_____	_____	_____

**Therapy session that you would like your child to attend. If it would be possible to bring your child to more than one session time, please indicate your preferences in order (ie. 1,2,3,4)**

\_\_\_\_\_ **8:00 - 10:00am**

\_\_\_\_\_ **10:30am – 12:30pm**

\_\_\_\_\_ **1:30pm – 3:30pm**

\_\_\_\_\_ **4:00pm - 6:00pm**

**\*\*Please note: If the session you are interested in is full, your child will be put on the waiting list.**

**Does the child currently receive Metrocare Services? Yes      No**

**If so, which services does he/she receive:** \_\_\_\_\_  
\_\_\_\_\_

**Name of Metrocare Services Case Manager/Case Coordinator:** \_\_\_\_\_

**Who referred you to us?** \_\_\_\_\_

**II. ADAPTIVE BEHAVIOR:**

**A. Self-Help skills: Independent    Verbal Prompts    Physical Assistance**

<b>Toileting</b>	_____	_____	_____	<b>(Not toilet trained ___)</b>
<b>Dressing</b>	_____	_____	_____	

<b>Eating</b>	_____	_____	_____
<b>Bathing</b>	_____	_____	_____
<b>Hand Washing</b>	_____	_____	_____

**B. Verbal/Communication Skills**

- \_\_\_ **No speech sounds**
- \_\_\_ **3-5 speech sounds**
- \_\_\_ **Babbles – with 3-5 speech sounds**
- \_\_\_ **Babbles with 5+ speech sounds**
- \_\_\_ **Can say at least 10 words**
- \_\_\_ **Echolalia (repeats)**
- \_\_\_ **Uses words or short phrases to communicate wants/needs.**

- \_\_\_ **Primary mode of communication is sign language**
- \_\_\_ **Approximate number of signs**

- \_\_\_ **Primary mode of communication is pictures/PECS**
- \_\_\_ **Approximate number of pictures/PECS**

**III. BEHAVIOR STATUS**

**A. Self-stimulatory Behaviors (ex: making noises/repeating phrases, hand flapping, rocking, spinning, heaving breathing)**

**1. Motor self-stimulation: specify** \_\_\_\_\_

- 
- \_\_\_ **occurs in most all settings**      \_\_\_ **occurs primarily when not engaged by another**
  - \_\_\_ **not observed**

**2. Vocal Self-stimulation: specify** \_\_\_\_\_

- 
- \_\_\_ **occurs in most all settings**      \_\_\_ **occurs primarily when not engaged by another**
  - \_\_\_ **not observed**

**3. Other self-stimulatory behaviors:** \_\_\_\_\_

**B. Self-Injury: (specify)** \_\_\_\_\_

\_\_\_\_\_

- \_\_\_\_\_ **Number of times/day**
- \_\_\_\_\_ **Occurs at home**
- \_\_\_\_\_ **Occurs at school**
- \_\_\_\_\_ **Occurs in all environments**

**Antecedents (triggers):** \_\_\_\_\_

**C. Aggression to Others: (specify)** \_\_\_\_\_

\_\_\_\_\_

- \_\_\_\_\_ **Number of times/day**
- \_\_\_\_\_ **Occurs at home**
- \_\_\_\_\_ **Occurs in all environments**

**Antecedents (triggers):** \_\_\_\_\_

**D. Other Challenging Behaviors (check all that apply)**

- \_\_\_\_\_ **Responds negatively to changes in the environment**
- \_\_\_\_\_ **Pica (eats inedible objects) specify** \_\_\_\_\_
- \_\_\_\_\_ **Unauthorized departure (runs off)**
- \_\_\_\_\_ **Spitting**
- \_\_\_\_\_ **screaming/tantrums**
- \_\_\_\_\_ **throwing/breaking objects**
- \_\_\_\_\_ **self injury(biting/banging)**
- \_\_\_\_\_ **inattention**
- \_\_\_\_\_ **hyperactivity**
- \_\_\_\_\_ **non-compliance**
- \_\_\_\_\_ **crying**

**Please describe the problems (circumstances, response to behaviors, etc.):** \_\_\_\_\_

**EVALUATIONS -If any of the following evaluations have been conducted, indicate the date and name of professional who administered the test.**

	DATE	PROFESSIONAL
<b>1. Psychological and/or Educational Evaluation</b>	_____	_____
<b>2. Speech and Language Assessment</b>	_____	_____
<b>3. Visual Examination</b>	_____	_____
<b>4. Hearing Evaluation</b>	_____	_____
<b>5. Neurological Evaluation</b>	_____	_____
<b>6. Medical Evaluation</b>	_____	_____

**CURRENT THERAPIES:**

			Number times/week
Speech/language therapy	Yes	No	_____
Occupational therapy		Yes	No _____
ABA therapy	Yes	No	_____

Other: \_\_\_\_\_

**MEDICAL: My child has in-depth medical attention for the following conditions(s).**

**\*\*Do NOT include routine illnesses:**

Allergies: \_\_\_\_\_

\_\_\_\_\_  
Child's Physician's Name      Address      Telephone Number

**Education History**

**SCHOOL HISTORY – List all schools attended by grade and year:**

	Grade	School Year	School
Current:	_____	_____	_____
Past:	_____	_____	_____
Past:	_____	_____	_____

Describe any difficulties: \_\_\_\_\_

Does child seem to have friends?      Yes No

Can child follow directions at school? Yes No

**Medical History**

**Has child been back in the hospital since birth? Yes No**

**Explain:** \_\_\_\_\_

**Has child had any unusual injuries or serious illness?**

\_\_\_\_\_

**Does child have allergies? Yes No**

**Explain:** \_\_\_\_\_

**Frequent colds? \_\_\_\_\_ Does child take medication regularly? If so, why?**

\_\_\_\_\_

**Has child had hearing tested? Yes No When? \_\_\_\_\_ Results?**

\_\_\_\_\_

**Does child have ear tubes? Yes No**

**Do you feel your child's general health has been**

**Poor fair good excellent?**

**General Information**

**What are your child's favorite activities?**

\_\_\_\_\_

**Has you child ever been involved in an ABA program? Yes No If so, briefly explain the program:** \_\_\_\_\_

**Service Provider/Consultant:** \_\_\_\_\_

**Locations/Dates:** \_\_\_\_\_

Names of trainers: \_\_\_\_\_

Goals accomplished: \_\_\_\_\_

**Parent Information**

Are parents: \_\_\_ married \_\_\_ separated \_\_\_ divorced

Who has custody of child? \_\_\_\_\_

Father's occupation? \_\_\_\_\_ level of education? \_\_\_\_\_

Place of employment? \_\_\_\_\_

Mother's occupation? \_\_\_\_\_ Level of education? \_\_\_\_\_

Place of employment? \_\_\_\_\_

If both parents work, what are child care arrangements:

\_\_\_\_\_

**\*\*\*\*A current copy of your child's Immunization Records MUST be provided prior to the first day of attendance.**

**I affirm that the information in this application is a complete and true statement of all the facts and circumstances relative to my child's application for enrollment.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



Metrocare – *the provider of choice*