FULL CIRCLE PEDIATRIC SOLUTIONS
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FULLCIRCLEPEDIATRIC.COM

# Application for Services

## Welcome to Full Circle Pediatric Solutions!

Our Mission: At Full Circle Pediatric Solutions, we are dedicated to serving children with varying needs and disabilities, along with their families, to reach their full potential. We believe in providing high quality, ethical services to allow for individualized growth and to develop lifelong skills by supporting the whole child—full circle.

Please complete this application honestly and accurately in order to ensure the most accurate assessment for your child. Email completed applications and any supporting documents to info@fullcirclepediatric.com or fax them to 701-478-0222. Please call 701-478-0221 if you have questions or need assistance in completing the application. Please attach the following supporting documents to your application (if applicable):

1. “Insurance Verification Form” (if seeking insurance reimbursement for services)
2. Copy of child’s diagnosis (if seeking insurance reimbursement for services)
3. Prescription for ABA or Speech/Language Therapy from child’s doctor (required for insurance companies)
4. “Release of Information” for any professionals that you would like for Full Circle staff to collaborate with regarding your child (Child’s doctor, school, speech therapists, occupational therapists, etc.). Please fill out one form for each separate organization.
5. Previous assessments and evaluations from ABA, Speech, and/or Occupational Therapies.
6. Reports, evaluations, assessments, goals and objectives from educational programs.
7. Medical assessment and/or evaluation reports that you feel are relevant to ABA Treatment (if any; these can also be turned in at a later date as needed).
8. Patient HIPAA Awareness Agreement

We look forward to working with you and your child. Welcome!

| Contact Information |
| --- |
| **Date:** |
| **Person completing form:** |
| **Relationship to client (child):** |
| **Best contact phone number:** |
| **Email address:** |
| **How did you hear about Full Circle:** |
| **Are you planning to seek insurance reimbursement for services?** Yes ☐ No ☐<br>**If yes, please fill out the "Insurance Verification Form" and submit with this application.* |

| Child Information |
| --- |
| **Child's name (first, middle, last):** |
| **Child's preferred name:** |
| **Child's date of birth (month, date, year):** |
| **Age:** |
| **Social Security #:** |
| **Custodial Parent(s)/Legal Guardian(s):** |
| **List any other individuals currently living in the home with child:** |

## Custodial Parent/Legal Guardian Information

| **Parent/Guardian #1:** | | |
|---|---|---|
| **First Name:** | **Last Name:** | **Relationship to Child:** |
| **Street Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** |
| **Email Address:** | | |
| **Address same as child?** Yes ☐ No ☐ | **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | |
| **Does this parent have custody of the child?** Yes ☐ No ☐ | **Type of Custody:** | |
| **Parent/Guardian #2:** | | |
| **First Name:** | **Last Name:** | **Relationship to Child:** |
| **Street Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** |
| **Email Address:** | | |
| **Address same as child?** Yes ☐ No ☐ | **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | |
| **Does this parent have custody of the child?** Yes ☐ No ☐ | **Type of Custody:** | |
| **What adults does the child live with? Check all that apply:** ☐ Birth Parent(s) ☐ Adoptive Parent(s) ☐ Foster Parent(s) ☐ Grandparent(s) ☐ Both Parents ☐ Parent/Guardian 1 Only ☐ Parent/Guardian 2 Only ☐ Other: | | |
| **Does the child have siblings or are there other siblings in the home?** Yes ☐ No ☐ | | |

| **Child 1 Name:** | **Age:** | **Speech/Behavior Concerns:** |
|---|---|---|
| **Child 2 Name:** | **Age:** | **Speech/Behavior Concerns:** |
| **Child 3 Name:** | **Age:** | **Speech/Behavior Concerns:** |
| **Child 4 Name:** | **Age:** | **Speech/Behavior Concerns:** |
| **Child 5 Name:** | **Age:** | **Speech/Behavior Concerns** |

| **Language(s) spoken in the home and who speaks the languages:** | |
|---|---|
| **Describe the child's use and understanding of the languages:** | |
| **Is there anything additional you would like to share about the family/home environment:** | |
| **Emergency Contact Name:** | **Phone:** |
| **Emergency Contact Relationship to Child:** | |
| **Will anyone else accompany/pick up/drop off your child?** Yes ☐ No ☐ | |
| **If yes, please list caregivers authorized to accompany/pick up/drop off your child during therapy sessions:** | |
| **Name:** | **Phone:** |
| **Name:** | **Phone:** |
| **Name:** | **Phone:** |

## Medical Information and History

| **Current Physician:**<br>**Name of Clinic:** | **Phone Number:** |
|---|---|
| **May we communicate with your physician:** Yes ☐ No ☐<br>**If "Yes", please fill out the "Release of Information" form and attach to application.* | |

| **Mother's Health During Pregnancy:** |
|---|
| 1. **Were there any infections or illnesses?** Yes ☐ No ☐<br>Describe: |
| 2. **Was there any stress during the pregnancy?** Yes ☐ No ☐<br>Describe: |
| 3. **Were there any complications during labor or delivery?** Yes ☐ No ☐<br>Describe: |
| **4. What was the mother's age at the time of delivery?** |
| **Child's Health:** |
| **1. How many weeks gestation was the child born in weeks?** (40 weeks is typical) |
| **2. What was the weight of the child and length of the child at birth?** |
| **3. How was the child delivered?** Vaginally ☐ Cesarean Section ☐ |

**Date and Results of Last Hearing Exam:**

**Date and Results of Last Vision Exam:**

**Please list any hearing, feeding, swallowing, or gastrointestinal issues now or in the past:**

*Check and describe all that apply:*

☐ Adenoidectomy ☐ Asthma ☐ Behavior Issues
☐ Brain injury ☐ Breathing problems ☐ Cardiac issues
☐ Chicken pox ☐ Diabetes ☐ Ear infections
☐ Ear tubes ☐ Encephalitis ☐ Frequent colds
☐ High fever ☐ Measles ☐ Meningitis
☐ Mumps ☐ Seizures ☐ Sensory issues
☐ Sleep issues ☐ Tongue tie ☐ Tonsillitis
☐ Tonsillectomy ☐ Traumatic brain injury ☐ Vision issues

Describe any boxes that were checked:

**Please list any surgeries or hospitalizations:**

**Has your child ever been admitted to a treatment center or hospital setting for any psychiatric, behavioral, medical, or crisis scenarios?** Yes ☐ No ☐
If yes, please describe:

**Please list any known allergies (including food allergies) or food restrictions:**

**Does the child currently use any equipment? (communication device, walker, etc.)?** Yes ☐ No ☐
If yes, please describe:

**Developmental History:** At what age did the child do the following

| | |
|---|---|
| Sit alone: | Combined Words: |
| Crawl: | Sentences: |
| Stand Up: | Fed Self: |
| Walk: | Understood by Others: |
| Made Sounds: | Toilet Trained: |
| First Word: | Dressed Self: |

Does the child do any of the following:

☐ Choke on liquids ☐ Choke on foods
☐ Avoid foods ☐ Maintain a special diet
☐ Use a pacifier / suck thumb ☐ Mouth objects

Please describe any of the above:

If under 4 years of age, how many words does the child say:

☐ 0-20 ☐ 21-50 ☐ 51-100 ☐ 101-150
☐ 151-300 ☐ 301-500 ☐ 501+

Does the child produce sentences of the following length:

☐ 2 words ☐ 3 words ☐ 4 words ☐ 5+ words

What percentage of the child's speech do you understand? %
How well do people outside of the family understand their speech? %

If the child is not using words, how do they communicate?

*Does the child have any difficulty with the following:*

| | |
|---|---|
| ☐ Attention | ☐ Frustration Tolerance |
| ☐ Aggression | ☐ Anger |
| ☐ Answering simple questions | ☐ Answering –wh questions |
| ☐ Understanding people | ☐ Following directions |
| ☐ Excessive drooling | ☐ Chewing or eating |
| ☐ Producing speech sounds | ☐ Stuttering |
| ☐ Reading | ☐ School work |
| ☐ Remembering | ☐ Maintaining eye contact |
| ☐ Transitions | ☐ Word Retrieval |
| ☐ Other difficulties: | |

Please describe any boxes that were checked:

**Official Diagnoses (list all that apply):**

| **Diagnosis** | **Date of Diagnosis** | **Age of Diagnosis** | **Referring Physician and Phone Number** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Medications your child is currently taking:**

| **Medication** | **Dosage** | **Time Given** | **Taken For?** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Educational Information & History

Please complete the following section regarding educational programming only (private or public classroom environments).

**Current School:**

**District:**

**Current Grade:**

**Program/Class Placement:**

**# Students in Classroom:**

**Staff to Student Ratio:**

**What type of educational environment?**

General Education ☐

Special Education ☐

Combination ☐

**If this is a Special Education environment, please describe the amount of inclusion that your child has in the general education environment/exposure to typically developing peers:**

**Days/Times of attendance:**

**Please provide information on any previous educational environments, classrooms, or districts in which your child has participated:**
**Please attach copies of all evaluations, reports, goals and objectives, IEPs, and diagnoses from each educational environment.*

## Social History

**Describe how the child interacts with parents, siblings, or other family members:**

**Please describe the communication difficulties the child faces in the home environment:**

**Describe any significant events or changes within the home:**

**What are the child's strengths?**

**What are the child's weaknesses?**

**What are the child's favorite items, activities, and interests?** (foods, toys, games, etc.)

**Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior?**

**Full Circle Pediatric Solutions**
Phone: 701-478-0221 Email: info@fullcirclepediatric.com

| **What are your goals for the child over the next 6 months?** |
|---|
| **What are your goals for the child over the next 5 years?** |
| **Is there anything else that is important for us to know about the child?** |

| **Evaluation** |
|---|
| **Briefly describe why you're seeking an evaluation by a speech-language pathologist and/or behavior analyst at this time**: |
| **What are you expecting out of this evaluation/meeting?** |
| **Has the child had a previous speech, language or feeding evaluation / treatment?**<br>Yes ☐ No ☐<br>**If yes, please attach reports* |
| **Has the child had previous applied behavior analysis therapy?**<br>Yes ☐ No ☐<br>**If yes, please attach reports* |
| **Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons**: |
| **At what age did you first notice the problem?** |
| **How do the child's communication and/or behavior difficulties impact the family?** |
| **If anyone else in the family has a speech/language diagnosis and/or behavior difficulties, please describe it:** |
| **Is the child aware of or frustrated by their communication difficulties?**<br>Yes ☐ No ☐ |