BREYTA
Behavioral Health

Service Inquiry

Client Name:			
Age:		**DOB:**	
Diagnosis			
Did your child previously receive ABA?	☐ Yes ☐ No		
If yes, provide the range of dates and the names of the providers:			

What services are you interested in? (Please check one from the list below)

- ☐ Morning Sessions
- ☐ Mid-Day Sessions
- ☐ Preschool Sessions
- ☐ Afternoon Sessions

How would you describe your child's verbal abilities? (Please check one from the list below)

- ☐ Non-verbal (does not use words or signs to express any wants or needs)
- ☐ Verbal (uses some words or signs to express wants or needs)
- ☐ High-verbal (uses sentences to communicate and engages in conversation)

How would you describe your child's problem behavior? (Please check one from the list below)

- ☐ Compliant (does not engage in any concerning behaviors)
- ☐ Mild/Moderate (engages in some problem behavior, such as crying, whining, tantrums)
- ☐ Severe (engages in high frequency of concerning behavior, such as hitting, biting, destruction)

Guardian Name: **Relationship:**

Contact Number:

Contact Email:

Primary Insurance Coverage	Secondary Insurance Coverage
Policy Holder:	Policy Holder:
Insurance Carrier:	Insurance Carrier:
Insurance Policy No:	Insurance Policy No:
Insurance Group No:	Insurance Group No:

Availability for Services

Please indicate your child's availability for therapy:

***Please note: Slots in the afternoons are primarily reserve for children over the age of 5.**

Days of the week	Day Time Shifts	Afternoon Shifts
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Comment:		

Clinical Documentation Checklist:

⇒ Primary Care Referral

⇒ Clinical Diagnostic Evaluation

⇒ IEP Documents

⇒ Speech Evaluation

⇒ Occupation Evaluation

Email the completed Service Inquiry Form to:

info@breytahealth.com