APPLE CONSULTING

Comprehensive Services for Autism Spectrum & Related Disorders.
For the Child. For the Family. For the School. For the Community.

Address: 1240 116th Ave NE Suite 102 Bellevue, WA 98004
Fax: 425-396-0729
Website: www.apple-asd.com

Main Line: 206-437-5412
Accounts Line: 206-250-9014
Email: Info@apple-asd.com

GENERAL INFORMATION SHEET

Please fill out the information below. Return this form with a copy of the front and back of your insurance card and a copy of your child's most recent diagnostic evaluation that includes his/her diagnosis.

Copy of insurance card? _____ Copy of Diagnostic evaluation?_____

If no copy of evaluation provided, why? _____

SERVICE INTERESTS:

☐ **ABA (In home)** ☐ **ABA (Clinic)** ☐ **School Support** ☐ **Other:** ☐ **Other:**

Availability: ☐ **Mornings (to noon)** ☐ **Early Afternoon (12-2)** ☐ **Mid Afternoon (2-4)** **Late Afternoon/Evening (4-7)**

REFERRED TO APPLE CONSULTING BY:

CHILD INFORMATION

CHILD'S NAME: _____ **BIRTHDATE:** _____ **GENDER:** _____

CHILD'S ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

FAMILY INFORMATION

MOTHER/PARENT/GUARDIAN'S NAME: _____ *☐ **EMAIL:** _____

PHONE NUMBERS - HOME: _____ **WORK** _____ **CELL:** _____

ADDRESS (if different from child): _____

FATHER/PARENT/GUARDIAN'S NAME: _____ *☐ **EMAIL:** _____

PHONE NUMBERS - HOME: _____ **WORK** _____ **CELL:** _____

ADDRESS (if different from child): _____

* ***Has Legal authority to make medical decisions on behalf of child***

HOUSEHOLD MEMBERS (Names & Relationship to Child – if sibling, include age)

_____

_____

PARENTS' MARITAL STATUS: ☐**MARRIED** ☐**SEPARATED*** ☐**DIVORCED*** ☐**OTHER:** _____

***CUSTODIAL PARENT:** _____

EMERGENCY CONTACT (other than parent):

NAME: _____ **RELATIONSHIP TO STUDENT:** _____

PHONE NUMBERS - HOME: _____ **WORK** _____ **CELL:** _____

Do you have any pets? __ Y __N If Yes, what kind? _____

MEDICAL

PRIMARY DIAGNOSIS (DX): _____ **DX DATE:** _____

DOCTOR WHO RENDERED DX: _____

OTHER DIAGNOSES: _____

ALLERGIES: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

MEDICATIONS: _____ **Purpose:** _____ **Dose:** _____

SUPPLEMENTS: _____

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

PRIMARY INSURED NAME: _____ **PRIMARY INSURED BIRTHDATE:** _____

EMPLOYER: _____ **EMPLOYER PHONE:** _____

GROUP ID#: _____ **INDIVIDUAL ID#:** _____

INSURANCE ADDRESS: _____

INSURANCE PHONE: _____

SECONDARY INSURANCE(IF APPLICABLE)

INSURANCE COMPANY NAME: _____

SECONDARY INSURED NAME: _____ **BIRTHDATE:** _____

EMPLOYER: _____ **EMPLOYER PHONE:** _____

GROUP ID#: _____ **INDIVIDUAL ID#:** _____

INSURANCE ADDRESS: _____ **INSURANCE PHONE:** _____

WILL YOU BILL THIS INSURANCE? ☐ **YES** ☐ **NO** **REASON:** _____

EDUCATIONAL INFORMATION

SCHOOL DISTRICT: _____

SCHOOL NAME: _____ **ATTENDS HOME SCHOOL?** ☐ **YES** ☐ **NO**

WHICH ENVIRONMENT(S) BEST DESCRIBE(S) YOUR CHILD'S SCHOOL PLACEMENT:

☐ **GENERAL EDUCATION (80-100% OF DAY)** ☐ **GENERAL EDUCATION (40-79%)** ☐ **RESOURCE ROOM**

☐ **GENERAL EDUCATION (0-39% OF DAY)** ☐ **PARA-EDUCATOR SUPPORT**

MY CHILD RECEIVES "SPECIALLY DESIGNED INSTRUCTION*" IN THE FOLLOWING AREAS:

*(*INSTRUCTION FOR AREAS NOT AT GRADE LEVEL AND/OR NEEDS EXTRA SUPPORT):*

☐ **SPEECH & LANGUAGE** ☐ **OT** ☐ **MATH** ☐ **READING** ☐ **WRITING** ☐ **SOCIAL SKILLS** ☐ **ADAPTIVE/BEHAVIOR**

☐ **EXECUTIVE FUNCTIONING** ☐ **PHYSICAL THERAPY** ☐ **OTHER:** _____ ☐ **OTHER:** _____