FOUNDATIONS
AUTISM CENTER

INTAKE FORM

DEMOGRAPHIC INFORMATION

Child's First Name : _____ Child's Last Name : _____

Date Of Birth : _____ SSN : _____ Gender : ☐ Male ☐ Female

Address : _____

City, State, Zip : _____

County of Residence : _____ Email : _____

Mother's Name : _____ Mother's Phone #: _____

Father's Name : _____ Father's Phone #: _____

INSURANCE INFORMATION

MN Medicaid # : _____ Straight MA: ☐ Yes ☐ No

Other Insurance : _____ Group #: _____ ID#: _____

Policy Holder Name : _____ SSN : _____

REASON FOR REFERRAL

Diagnosis : _____

Child's Strengths : _____

Child's Struggles : _____

Goals for Child : _____

MEDICAL PROVIDERS

Primary Physician: _____ Physician Phone #: _____

Physician Address: _____ City, State, Zip: _____

Specialist Provider: _____ Specialist Phone #: _____

Specialist Address: _____ City, State, Zip: _____

Specialist Provider: _____ Specialist Phone #: _____

Specialist Address: _____ City, State, Zip: _____

OTHER PROVIDERS - EIDBI, ABA, OT, SPEECH, ETC.

Provider Name: _____ **Therapy Type:** _____

Company Name: _____ **Phone:** _____

Company Address: _____ **City, State, Zip:** _____

Provider Name: _____ **Therapy Type:** _____

Company Name: _____ **Phone:** _____

Company Address: _____ **City, State, Zip:** _____

Provider Name: _____ **Therapy Type:** _____

Company Name: _____ **Phone:** _____

Company Address: _____ **City, State, Zip:** _____

Provider Name: _____ **Therapy Type:** _____

Company Name: _____ **Phone:** _____

Company Address: _____ **City, State, Zip:** _____

OTHER INFORMATION YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD