

**Initial Contact Form**

* Your name (person completing form) and your relationship to child/client:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Child's name, date of birth & gender:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_\_\_\_ M / F

* Child’s current diagnosis (check all that apply):

Autism Spectrum Disorder (ASD) \_\_\_\_ Attention Deficit Hyperactivity Disorder (ADHD) \_\_\_\_

Attention Deficit Disorder (ADD) \_\_\_\_ Genetic Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizure Disorder: \_\_\_\_\_\_\_\_\_

Oppositional Defiant Disorder (ODD) \_\_\_\_ Cerebral Palsy \_\_\_\_

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Insurance Company: (Primary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Secondary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address:
* Your phone number: Email address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* What concerns (\*behavioral or developmental) brought you to us? Please be specific what changes you would like to see in your child’s behavior or skills.

* How did you hear about us?

Please sign below, to verify the info provided above is correct, and to give us permission to contact you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Printed Name Date

\*  **Return completed form to** **info@projecthopefl.com** **or Fax to 561-242-1726.**