



8920 HOLLY AVE NE STE 102B ALBUQUERQUE, NM 87122
Phone: (505) 856-6880 FAX: (800) 714-4705

CLIENT INFORMATION FORM

PLEASE COMPLETE THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

IF YOU HAVE QUESTIONS OR NEED ASSISTANCE COMPLETING THIS FORM, PLEASE CONTACT OUR OFFICE AT (505) 856-6880 OR EMAIL AT ADMIN@BRIDGESINC.INFO

CLIENT'S NAME: _____

DATE OF BIRTH: ____/____/____ GENDER: M F

PARENT/GUARDIAN NAME(S): _____

PARENT/GUARDIAN ADDRESS: _____

EMAIL: _____

PARENT/GUARDIAN PHONE: HOME _____ CELL _____

DATE COMPLETED: ____/____/____ COMPLETED BY: _____

YOUR RELATIONSHIP TO CLIENT: _____

WHAT IS YOUR LANGUAGE PREFERENCE? _____

LIST ALL LANGUAGES REGULARLY SPOKEN WITH CLIENT: _____

ARE THERE ANY CULTURAL OR RELIGIOUS CONSIDERATIONS YOU'D LIKE US TO BE AWARE OF:
____ YES ____ NO

IF YES, PLEASE DESCRIBE: _____

PRIMARY DIAGNOSIS: _____ BY WHOM: _____ DATE: _____

SECONDARY DIAGNOSIS (if any) _____ BY WHOM: _____ DATE: _____

HOW DID YOU HEAR ABOUT BRIDGES? _____

PLEASE DESCRIBE ANY LEGAL STATUS OR ONGOING CONCERNS BRIDGES SHOULD BE AWARE OF (FOR EXAMPLE, CUSTODY, GUARDIANSHIP, CYFD INVOLVEMENT, ETC.):

DESCRIBE ANY CONCERNS YOU HAVE ABOUT THE CLIENT:

WHAT WOULD YOU LIKE THE CLIENT TO LEARN?

IS YOUR CHILD VERBAL?

___ YES ___ NO

DOES THE CLIENT HAVE TANTRUMS, BEHAVIOR OUTBURSTS, OR OTHER CHALLENGING BEHAVIORS? EXAMPLES: AGGRESSION, INAPPROPRIATE LANGUAGE, ETC.?

___ YES ___ NO IF YES, PLEASE DESCRIBE:

WHAT WOULD YOU AS A PARENT/CAREGIVER LIKE TO LEARN OR RECEIVE SUPPORT WITH?

HAS THE CLIENT HAD A DEVELOPMENTAL OR SKILLS ASSESSMENT CONDUCTED BY ANOTHER SOURCE IN THE PAST (ie. VBMAPP, ABLLS, VINELAND, AFLS, PEAK, etc.) ___ YES ___ NO

IF YES, PLEASE LIST BELOW

WHAT OTHER BRIDGES SERVICES ARE YOU INTERESTED IN (check all that apply)?

Sibling Support Group

Social Skills Group

PLEASE LIST ALL CLIENT'S HOSPITALIZATIONS: (medical, psychiatric, and residential)

DATE

REASON

EDUCATIONAL AND THERAPUTIC SERVICES

SCHOOL NAME: _____ CURRENT GRADE: _____

TYPE OF CLASS: (i.e. GENERAL EDUCATION, SPECIAL EDUCATION, INCLUSION)

ANY CURRENT OR PAST EARLY INTERVENTION SERVICES: ____ YES ____ NO

IF YES, PLEASE LIST THE PROGRAMS AND LOCATIONS:

PLEASE LIST PROVIDERS FOR **ALL SERVICES** CLIENT CURRENTLY RECEIVES:

(If any services are provided by the school please indicate as "school service")

SPEECH THERAPY: _____

OCCUPATIONAL THERAPY: _____

HIPPOTHERAPY: _____

COUNSELING: _____

FAMILY COUNSELING: _____

BEHAVIOR THERAPY: _____

PLAY THERAPY: _____

MUSIC THERAPY: _____

PHYSICAL THERAPY: _____

PSYCHIATRIC/PSYCHOTROPIC MEDICATION MANAGEMENT: _____

OTHER: _____



Bridges, Inc. | 8920 Holly Ave NE Suite 102B, Albuquerque, NM 87122 | 505-856-6880

Record of Insurance

INCLUDE A COPY OF ALL APPLICABLE AND CURRENT INSURANCE CARDS IN ORDER FOR US TO DETERMINE ELIGIBILITY OF SERVICES (MEDICAID AND PRIVATE INSURANCE) In order for Bridges, Inc. to properly submit claims for services rendered we require a record of all active insurance plans the client may be covered under. Please provide information below for all active insurance plans whether you believe the insurance plan will cover rendered services or not. Failure to disclose all active insurance plans may result in the responsible party becoming financially liable for the full balance of services performed.

Record of Insurance for: _____,

including, but not limited to: Primary coverage, Secondary coverage or Tertiary coverage.

	Insurance Name	Member #/Subscriber ID
Primary		
Secondary		
Tertiary		
Other: Grants, Trusts, etc.		

By signing you acknowledge all active insurance plans have been identified and all is correct and accurate to the best of your knowledge:

Signature: _____

Print: _____ Date: _____



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Block Schedule Availability Form, School Year 2017-2018: August 1 – May 31

Please fill out the availability form to indicate when the client is able to receive ABA Services. *Check the box(es) that corresponds to the block of time available for scheduling.* We will schedule your sessions anywhere within this block of time. **Please note that the more availability you provide, the greater our ability to meet your desired number of hours.** For clients receiving services in the school setting, please indicate “school” in the box where you would prefer these sessions.

Please submit at least 6 additional hours over what your desired hours are. Example: 12 desired hours, submit 18 hours of availability.

Client’s name: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9:00 AM-12:00 PM						
1:00 PM-4:00 PM						
4:30 PM-6:30 PM						

Weekly hours desired (15 hour minimum): _____

Place of Service: _____

Additional scheduling information that Bridges should be aware of: _____

Vacation Dates August - May: _____

