ATRI™

CLINICAL FORMS TOOLKIT

Clinical Forms Toolkit

Professional Documentation
from Intake Through Follow-Up

3 Editable Clinical Forms

Professional & Ethical

Intake to Follow-Up

Part of the **AbaTools** ATRI Clinical Framework

WHAT'S INCLUDED

What's Included in This Kit

This kit includes 3 essential clinical forms to support professional documentation from intake to follow-up.

01 Detailed Child Intake Form

Structured form for collecting initial information about the child's history, development, and family context.

Used during first consultation

02 Therapeutic Agreement

Formal agreement that outlines the treatment plan, responsibilities, fees, and policies.

Used at treatment initiation

03 Monthly Progress Report

Standardized report to track progress, adjust goals, and document clinical observations over time.

Used throughout follow-up

These forms are editable and can be adapted to your clinical practice and setting.

FORM 01

Child Intake Form

Detailed information to support comprehensive understanding and individualized clinical planning.

A. PATIENT INFORMATION

Full Name: _____

Date of Birth: _____ Age: _____

School / Daycare: _____

B. PREGNANCY & BIRTH HISTORY

Type of Pregnancy: _____

Type of Birth: _____

Complications / Intercurrences: _____

C. DEVELOPMENTAL MILESTONES

Head Control (age): _____

Sitting (age): _____

Walking (age): _____

First Words (age): _____

First Phrases (age): _____

Toilet Training (age): _____

D. INITIAL CLINICAL OBSERVATIONS

Describe relevant behaviors, strengths, challenges, communication, social interaction, sensory responses and any other important observations.

Date of Intake: ____ / ____ / _____

Completed by: _____

FORM 02

Therapeutic Agreement

Agreement between professional, patient, and responsible party regarding treatment goals, policies, and responsibilities.

A. TREATMENT GOALS

Primary goals of treatment:

_____

_____

_____

_____

B. SESSION FREQUENCY & DURATION

Frequency: _____ sessions per ☐ Week ☐ Month ☐ Other: _____

Session duration: _____ minutes

C. FEES & PAYMENT TERMS

Rate per session: _____

Payment method: ☐ Cash ☐ Credit/Debit ☐ Insurance ☐ Other: _____

Payment schedule: _____

Late cancellation / no-show fee: _____

D. CANCELLATION POLICY

Please describe the cancellation policy:

_____

_____

_____

E. SIGNATURES

Parent / Guardian Name: _____

Signature: _____

Date: ____ / ____ / _____

Professional Name: _____

Signature: _____

License Number: _____

Date: ____ / ____ / _____

FORM 03

Monthly Progress Report

Record of progress, clinical observations, and treatment adjustments.

Patient Name: _____ Reference Month: _____

Sessions Completed: _____ Sessions Missed: _____

A. GOALS ADDRESSED

List the goals targeted during this month:

_____

_____

_____

_____

B. OBSERVED PROGRESS

Describe progress observed toward each goal and overall functioning:

_____

_____

_____

_____

_____

C. TREATMENT ADJUSTMENTS

Describe any changes made to the treatment plan, strategies, or targets:

_____

_____

_____

D. RECOMMENDATIONS FOR NEXT MONTH

Recommendations for strategies, supports, or goals to focus on next month:

_____

_____

_____

PROFESSIONAL SIGNATURE

Name: _____

Signature: _____

License Number: _____

DATE

Date Completed: _____

Next Review Date: _____