

## Intake Information

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Guardian: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

### **Employment Information**

Mother Occupation: \_\_\_\_\_ Title: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father Occupation: \_\_\_\_\_ Title: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Guardian Occupation: \_\_\_\_\_ Title: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Contact in case of emergency or if a session has to be cancelled: \_\_\_\_\_

Siblings' names and ages: \_\_\_\_\_

School: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

District: \_\_\_\_\_ Teacher(s): \_\_\_\_\_

### **General Information**

What is your primary reason for today's assessment? \_\_\_\_\_

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When did you first notice this difficulty and who brought it to your attention? \_\_\_\_\_

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What would you like to have happen as a result of the assessment and/or cognitive educational therapy?  
(Your goals for your child) \_\_\_\_\_

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Indicate any diagnosis/label/disorder that has been used to describe your child: ADD Autism/PDD/  
Asperger Learning Disability Dyslexia/Reading Problem ADHD Anxiety Disorder Speech/Language  
Delay Auditory Processing Disorder Other \_\_\_\_\_

**Academic History**

Is your child achieving at expected levels in school? Yes No Comment: \_\_\_\_\_

Type of classroom in school: Mainstream Special Special help classroom for some subjects

Has your child repeated a grade? Yes No Which grade? \_\_\_\_\_ Reason: \_\_\_\_\_

Please check any problem areas: Reading Comprehension Loses place/ skips lines Avoidance of schoolwork Writing Listening Letter/number reversals Works too hard on schoolwork Spelling Speech/ articulation Overly active Attention/concentration Math Verbal expression Low self-esteem Motivation/behavior Slow Work Processing Poor memory Argumentative

List any current or past help/ tutoring that your child has received in or out of school: \_\_\_\_\_

How does your child feel about his/her success as a student? \_\_\_\_\_

Are there difficulties completing homework? \_\_\_\_\_ please explain: \_\_\_\_\_

Is there family history of learning difficulties or challenges in school? \_\_\_\_\_ briefly describe: \_\_\_\_\_

**Medical History**

Birth was: Premature Late Caesarian Birth weight: \_\_\_\_\_ Complications in pregnancy or delivery? \_\_\_\_\_

Is your child currently under a doctor’s care or on any medications? Yes No

Reason: \_\_\_\_\_

List medications: \_\_\_\_\_

Is there anything else you feel we should know to help in the evaluation program set-up for your child? \_\_\_\_\_

How would you describe your student’s overall health? \_\_\_\_\_

Date of most recent Physical: \_\_\_\_\_ Eye Exam: \_\_\_\_\_ Hearing Exam \_\_\_\_\_

**Nutrition and Sleep**

Would you describe your child as a picky eater? If so, why? \_\_\_\_\_

Favorite food: \_\_\_\_\_ Vitamins: \_\_\_\_\_

Does your child have difficulty:

- Falling asleep
- Staying asleep
- Wetting the bed
- Sleep walking
- Night terrors

Please describe your typical daily routine:

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Describe your child's appetite. Are there any food allergies?

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### **Social/Emotional History**

Has your child ever had emotional or behavioral problems? (If yes, please describe):

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Please describe the student's attitude toward the following:

Brothers and sisters: \_\_\_\_\_

Playmates and peers: \_\_\_\_\_

Does your child prefer to play alone or with other children? \_\_\_\_\_

Does your child play easily with other children? (If no, please describe)

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What does your child like to do when they are not in school?

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### **Feelings/Attitudes Toward School**

What are your child's favorite subjects in school?

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What are your child's least favorite subjects?

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In general, what is your child's attitude toward school?

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**Other Information I Should Know About Your Child:**

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How did you hear about us? Who may we thank for referring you? \_\_\_\_\_

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Parent/ Guardian Signature

Relationship

Date