HOLLAND CENTER

INTAKE PACKET FOR (check all that apply): ☐ ABA services ☐ Diagnostic Testing

CLIENT INFORMATION

Child's Name (Last, First MI):______________________________

Sex:__________ DOB(mm/dd/yyyy):____________________ Age:______ Grade:______________

Height:________________________ Weight:_____________________

The questions listed below are voluntary. Information is requested for demographic/record keeping purposes only.

Child's ethnicity/race (check only one):

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Hispanic or Latino
☐ White or Caucasian

Primary language spoken at home: ______________________________
Secondary language spoken at home (if applicable): ______________________________

CONTACT INFORMATION

Name of Person Completing this Form: ______________________________

Relationship to Child: ______________________________

Today's Date: ______________________________

How did you hear about Holland Center? ______________________________

FAMILY INFORMATION

Mother/ Legal Guardian: ______________________________

Age: ____________ DOB(mm/dd/yyyy): ________________ Occupation: ________________

Total Years of Education: ________ Highest Educational Degree: ______________________

Daytime Phone________________________ Cell Phone: ______________________

Address: ______________________________

E-mail Address(s): ______________________________

RELATIONSHIP: ☐Biological Parent ☐Step Parent ☐Adoptive/Foster Parent ☐Other__________

Father/ Legal Guardian: ______________________________

Age: ____________ DOB(mm/dd/yyyy): ________________ Occupation: ________________

Total Years of Education: ________ Highest Educational Degree: ______________________

Daytime Phone________________________ Cell Phone: ______________________

Address: ______________________________

E-mail Address(s): ______________________________

RELATIONSHIP: ☐Biological Parent ☐Step Parent ☐Adoptive/Foster Parent ☐Other__________

Child lives with (*check all that apply*): ☐Father ☐Mother ☐Other (specify) ___________________

Parents are: ☐ Married (number of years _________) ☐ Separated (in ________/__________)

☐ Divorced (in _________/_________) ☐ Never Married ☐Widowed (in _________/__________)

Is your child adopted? ☐No ☐Yes Is your child aware of the adoption? ☐ No ☐Yes
If your child was adopted, at which age and from where:

____

Siblings:

	Name	Age	Relationship	Living in Home?
1.	______________________	________	________________________	Y/N
2.	______________________	________	________________________	Y/N
3.	______________________	________	________________________	Y/N
4.	______________________	________	________________________	Y/N

REFERRAL INFORMATION

Primary Physician: ____ Phone:______________________

Primary Physician Address: ____

Referring Physician: _______________________________________Phone:______________________

Referring Physician Address: ____

Anticipated Source(s) of Funding: ☐ MA ☐ Private Pay ☐ Insurance

Will insurance company cover this evaluation? ☐No ☐Yes ☐ Don't know

Primary Insurance:

Policy Holder: _______________________ DOB: ________ Place of Employment: ________________

Insurance Carrier: ____

Group #: _____________________ ID#______________________ Policy #:______________________

Secondary Insurance (if applicable):

Policy Holder: _______________________ DOB: ________ Place of Employment: ________________

Insurance Carrier: ____

Group #: _____________________ ID#______________________ Policy #:______________________

Medical Assistance/TEFRA (if applicable):

Policy Holder: _______________________ DOB: ________ Place of Employment: ________________

Group #: _____________________ ID#______________________ Policy #:______________________

Please include a copy of all insurance cards (front and back) listed above.
Briefly describe the primary reason you are seeking an evaluation at the Holland Center.

Briefly describe the primary reason you are seeking an services for your child.

____

____

Please list your 3 primary questions or concerns you would like addressed:

1. ____
2. ____
3. ____

Describe additional concerns about your child's development (including social interaction, communication, play, language and behavior).

____

____

____

____

Does the individual currently have an Autism Spectrum Disorder diagnosis?

☐ Autism ☐ Asperger's Syndrome ☐ PDD-NOS ☐ No Current ASD Diagnosis

Who made this diagnosis?______________________________________Date: ___________

Does the Individual currently have any of the following diagnoses?

	Diagnosed by:	Date
☐ Depression	____________________	________
☐ Anxiety Disorder	____________________	________
☐ ADHD	____________________	________
☐ OCD	____________________	________
☐ Tourette's Syndrome	____________________	________
☐ ODD/Conduct Disorder	____________________	________
☐ Learning Disability	____________________	________
☐ Intellectual Disability/MR	____________________	________
☐ Sensory Integration Disorder (SID)	____________________	________
☐ Epilepsy/Seizure Disorder	____________________	________
☐ Other	____________________	________

Has the child you are seeking services for been evaluated in the past? ☐ Yes ☐ No

If Yes, please list the following information on the previous evaluation(s):

	Who	Type	When
1.	____________	____________	________
2.	____________	____________	________
3.	____________	____________	________
4.	____________	____________	________

PLEASE INCLUDE COPIES OF ANY PAST REPORTS/EVALUATIONS WHEN RETURNING THIS PACKET

FAMILY MEDICAL AND PSYCHOLOGICAL HISTORY

Please indicate all medical conditions that have occurred in the child's biological relatives. Indicate which relative in the space provided. Under sibling, indicate sister (S) or brother (B). For all other relatives, indicate which side of the family, mother (M) or father (F). For example, if the child's mother's sister has a learning disability, you would place an "M" in the box under "Aunt" in the column labeled "learning disability."

	Mother	Father	Sibling	Aunt	Uncle	Cousin	Grandparent	Other
Learning disability								
Attention deficit disorder								
Mental retardation								
Autism								
Pervasive development disorder								
Speech and language disorder								
Hearing loss/deafness								
Tourette's or tic disorder								
Congenital disorder								
Thyroid disease								
Chronic illness (please list: such as asthma, arthritis, diabetes, lupus)								
Depression								
Bipolar Disorder								
Suicide attempt								
Anxiety								
Obsessive Compulsive Disorder								
Schizophrenia								
Psychiatric hospitalization								
Alcohol dependency								
Chemical dependency								
Other								

Please provide additional information about any checkmarks above.

____

____

____

____

Is there any other family history that would be important for us to know?

____

____

____

PREGNANCY AND BIRTH INFORMATION

The pregnancy was mother's __________ (number) of __________ (number) pregnancies with _________ (number) live births.

Prior to this individual, were there difficulties getting pregnant? ☐ Yes ☐ No

Were there any difficulties getting pregnant with this individual ☐ Yes ☐ No

Did any of the following occur before the pregnancy? ☐ Fertility medications ☐ Miscarriages

How many miscarriages did the biological mother have, prior to this individual? _______________

How many abortions did the biological mother have, prior to this individual? _________________

Did any of the following occur during the pregnancy?

☐ Maternal injury, describe:	☐ Infections, describe:	☐ Bleeding, spotting, which months:	☐ X-rays, which months:
☐ Abnormal weight gain	☐ Poor weight gain	☐ Excessive vomiting	☐ Hypertension
☐ Toxemia	☐ Anemia	☐ Exposure to toxins	☐ Measles
☐ Gestational diabetes	☐ Alcohol use: amount per day:	☐ Cigarette use: amount per day:	☐ Trauma
☐ Abnormal emotional stress (such as work hours, death of a relative)	☐ Medication use- describe/ which months:	☐ Drugs (such as cocaine, marijuana), which months:	☐ Prenatal testing (such as CMV, HIV, TORCH)

Please elaborate on any difficulties experienced during pregnancy.

____

____

Mother's age at time of delivery: ____________________ Father's age ______________________

Hospital, city and state of birth____

Did the birth mother receive regular pre-natal care? ☐ Yes ☐ No

Length of pregnancy: _________ weeks (if an infant is born on his due date, the pregnancy is 40 weeks long)

Was it: ☐ A single birth ☐ Twins ☐ Multiples (3+)

How did labor begin? ☐ Naturally ☐ Induced ☐ Emergency

How long did labor last? ____

What drugs were used to assist with labor/delivery?

____

____

How was the child delivered?

☐Vaginal--- Normal Vertex Position (Head First) ☐Planned Caesarean Section

☐Vaginal---Breech (Leg Or Bottom First) ☐Emergency Caesarean Section

☐Vaginal---Face First

What was the child's weight at birth? _______ lbs. ______ oz. Length? ________ in. OR ________cm.
Apgar scores __________ 1 minute __________ 5 minutes

Child's condition at birth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't know
Length of hospital stay: Infant_______________________ Mother __________________________

Were any of the following experienced during delivery?

☐ Excessive bleeding ☐ Meconium staining ☐ Forceps/Suction used
☐ Infection ☐ Fever ☐ Labor stopped
☐ Infant had difficulty breathing ☐ Placenta previa/abruptio ☐ Jaundice
☐ Umbilical cord around infant's neck ☐ Other:______________________

Were there concerns about the infant's condition immediately after birth? ☐ Yes ☐ No
Were there any congenital defects/anomalies evident at birth? ☐ Yes ☐ No
Did the infant need medical intervention (e.g. incubator, oxygen, surgery, blood transfusion, etc.) after birth? ☐ Yes ☐ No
Please elaborate on any difficulties/concerns experienced during labor and deliver.

____

____

Is there any other information about the mother or baby that may be pertinent? ____________

____

____

DEVELOPMENTAL INFORMATION

Please describe your child's temperament at the following ages:

Infancy (birth to 12 mo.) ☐ Pleasant/happy ☐ Fussy Colicky ☐ Other
Toddler (12 to 36 mo.) ☐ Pleasant/happy ☐ Fussy Colicky ☐ Other
Preschool (36 to 60 mo.) ☐ Pleasant/happy ☐ Fussy Colicky ☐ Other

Was there anything unusual about how your child developed? (such as didn't like to be held, very early interest in numbers)

____

____

How was the child fed: ☐ Breast fed until _________months ☐Bottle fed ☐ Both
Were there any feeding difficulties? ☐ Yes ☐ No

Did the baby have problems gaining weight? ☐ Yes ☐ No
If yes, please explain:

____

BIRTH TO ONE YEAR

In the first year, did your infant experience any of the following?

☐ Breathing problems ☐ Irritability ☐ Injury
☐ Feeding problems ☐ Sleep problems ☐ Developmental delay
☐ Weight loss or poor weight gain ☐ Ear infections ☐ Other infections

ONE TO THREE YEARS

From age one to three, did any of the following occur?

☐ Excessive temper tantrums ☐ Separation problems ☐ Sleep problems
☐ Developmental delay ☐ Recurrent ear infections ☐ Behavior problems
☐ Ear tubes inserted

THREE TO FIVE YEARS

From age three to five, did any of the following occur?

☐ Excessive temper tantrums ☐ Recurrent ear infections ☐ Difficulty with transitions
☐ Developmental delay ☐ Sleep problems ☐ Ear tubes inserted
☐ Toileting problems ☐ Behavior problems ☐ High activity level
☐ Separation problems ☐ Difficulty with structured activity ☐ Short attention span

Did preschool teachers, day care providers or other caregivers observe difficulty with any of the following?

☐ Structured activity ☐ Peer relationships ☐ Attention
☐ Behavior ☐ Group activity ☐ Transitions

At what age did your child first do the following? Please indicate age in months (such as 16 mo.) If skill has not yet been acquired, place an X on the line:

________Smiled ________Held head erect ________Separated easily from mother
________Imitated sounds ________Rolled over ________Fed self with spoon
________Babbled ________Sat alone ________Ate Table Foods
________Said other single words ________Crawled ________Bowel trained
________Said “mama” or “dada” ________Walked alone ________Bladder trained
________Followed simple directions ________Rode tricycle ________Dry at night
________Said 2-3 word phrases ________Dressed self ________Grasped a Crayon
________Knew colors ________Started counting ________Read words
________Recited total alphabet ________Tied shoes

Has your child ever gained skills and then lost them in any developmental area (i.e. language, toileting, motor skills?) ☐ Yes ☐ No

If yes, please explain: ____

____

Please comment on the following behaviors for your child as an infant and as a toddler:

How active is your child? ____

How well does your child deal with transition and change? ______________________

____

How well does your child respond to new places, people, and things? ______________

____

How is your child's basic mood? Happy? Sad? Angry? Quiet? Other, please explain.

____

Is your child predicable in patterns of sleep, appetite, etc.? ______________________________

____

PHYSICAL HEALTH INFORMATION

What is the current health status of your child?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Do you have any specific medical concerns about your child? ☐ Yes ☐ No

____

____

Has your child had any of the following? (Check all that apply):

☐ Adenoidectomy
☐ Breathing difficulties/Asthma
☐ Chicken Pox
☐ Seizures
☐ Broken bones
☐ Ear Tubes – When:
☐ Head injury/ concussion
☐ Tonsillectomy
☐ High Fevers
☐ Meningitis
☐ Blood disorder
☐ Ear Infections - How often/many:
☐ Sleeping difficulties
☐ Lead poisoning
☐ Diabetes
☐ Vision Problems
☐ Hearing problems–hearing loss
☐ Prolonged illness:

Other serious injuries/surgeries____

Hospitalizations (reason) Dates

____ _____________________

____ _____________________

Does your child, or have they in the past, taken medications on a daily basis? ☐ Yes ☐ No
If yes, please complete the table below and include present and past medications taken for an extended period of time.

Name of medication	Purpose	Dosage	When started

Is your child's allergic to any medications? If yes, please list medications. ☐ Yes ☐ No

____

____

Please list in detail all known allergies (include food, animal, plants/other): ________________

____

____

Are your child's immunizations up-to-date? ☐ Yes ☐ No ☐ Don't know

When was your child's last complete physical?______________________________________

Have you ever questioned your child's ability to hear normally? ☐ Yes ☐ No

If yes, please explain: ____

When was your child's hearing last screened and what were the results?

____

Have you ever questioned your child's ability to see normally? ☐ Yes ☐ No

When was your child's vision last screened and what were the results?

____

Please include a copy of all Audiology and Vision evaluation reports.

Has your child received Genetic Testing? ☐ Yes ☐ No

If yes, please include a copy of the Genetic testing reports.

Is your child currently seeing any medical specialists or therapists (such as neurology, occupational therapy or physical therapy)? ☐ Yes ☐ No

If yes, please provide name: ____

Which hand does your child use to complete tasks? ☐ Right ☐ Left ☐ Both

Does your child have problems with coordination? ☐ Yes ☐ No

☐ Large motor coordination

☐ Small motor coordination (such as handwriting, cutting or sipping)

Does your child experience any of the following difficulties with sleep? ☐ Yes ☐ No

☐ Difficulty falling asleep ☐ Waking in the night ☐ Nightmares ☐ Early morning waking

☐ Night terrors ☐ Sleeps too much ☐ Snoring ☐ Apnea

☐ Falls asleep during day (other than age-appropriate naps) ☐ Other: ____________________

Does your child have any of the following difficulties with elimination? ☐ Yes ☐ No

☐ Daytime wetting ☐ Toilet refusal ☐ Night wetting

☐ Constipation ☐ Soiling ☐ Diarrhea

☐ Other: ____

Does your child frequently complain of physical symptoms not related to a medical problem? ☐ Yes ☐ No

☐ Stomachaches ☐ Headaches ☐ Joint aches

☐ Fatigue ☐ Dizziness ☐ Heart palpitations

☐ Breathing problems ☐ Tremors/shakes ☐ Other: ____________________

Does your child have any of the following difficulties with eating? ☐ Yes ☐ No

☐ Difficulty sitting at the table ☐ Overeats ☐ Avoids foods due to texture

☐ Poor food choices ☐ Picky eater ☐ Odd eating behavior/habits

☐ Chokes on foods or liquids ☐ Other: ______________________________

Does your child have a very limited number of foods he/she is willing to eat? ☐ Yes ☐ No
If yes, what foods? ______________________________

____

Is your child currently on a Gluten Free-Casein Free Diet? ☐ Yes ☐ No

Are there any other diet restrictions? ☐ Yes ☐ No
If yes, please list: ______________________________

____

Do you have any other concerns about your child's current eating habits?

____

____

BEHAVIORAL INFORMATION

Behavioral characteristics your child demonstrates (Check all that apply):

☐ Cooperative/attentive ☐ Craves touch ☐ Plays/shares well with others

☐ Willing to try new activities ☐ Shy/quiet ☐ Poor eye contact

☐ Usually happy/easy going ☐ Easily Frustrated ☐ Repetitive behavior

☐ Short attention span/restless ☐ Tires easily ☐ Impulsive/distractible

☐ Destructive/aggressive ☐ Withdrawn ☐ Stubborn/resistant to change

☐ Self-abusive behavior ☐ Avoids Touch ☐ Difficulty waiting /accepting no

☐ Problems transitioning to other activities ☐ Other: ______________________________

How frequently does your child display each of the following?

Behavior	Daily	Weekly	Monthly	N/A
Crying/Screaming				
Tantrums				
Aggressive Behaviors				
Please Describe (e.g., kicks, pinches, etc.):				
Self-Injurious Behaviors				
Please Describe (e.g., hits head, bites self, etc.):				
Property Destruction				
Please Describe (e.g., throws objects, rips materials, etc.):				

Has your child ever had a behavior plan to address challenging behaviors? ☐ Yes ☐ No

If yes, please include a copy of your child's behavior plan.

Please explain any additional concern(s) you may have about your child's challenging behaviors: ____________________

____

____

____

____

How do you discipline your child? Please give an example.

____

____

____

____

Does your child display any unusual repetitive movements or noises (tics)?

- ☐ Head, facial or neck twitches
- ☐ Walks in unusual manner
- ☐ Nervous habits, describe: ____________________
- ☐ Problems with balance
- ☐ Walks on tiptoes
- ☐ Is generally clumsy
- ☐ Repetitive actions when excited, describe: ____________________
- ☐ Other: ____________________

Does your child act in any of the following ways?

- ☐ Frequently seems unaware of others in room, fails to react to noise
- ☐ Echoes or repeats words or phrases over and over
- ☐ High pain tolerance
- ☐ Repeats same behavior
- ☐ Becomes agitated if not permitted to perform ritual or routine behavior
- ☐ Seems unafraid of dangerous activity (such as shows no fear when on high playground equipment)
- ☐ Speaks using sing-song or high pitched intonation

Does your child currently…

… have an unusually strong interest in particular topic(s)/ subject(s)? ☐ Yes ☐ No

If yes, what theme(s)/subject(s)? ____________________

…play with toys or household objects in an unusual manner? ☐ Yes ☐ No

If yes, how so? ____________________

____

…have particularly strong reactions to loud noises (e.g. sirens, vacuums)? ☐ Yes ☐ No

…have particularly strong reactions to bright lights? ☐ Yes ☐ No

…stare closely at spinning objects or fingers? ☐ Yes ☐ No

…seem to enjoy running/rocking back and forth or spinning in circles/bouncing? ☐ Yes ☐ No

…enjoy touching/rubbing certain textures? ☐ Yes ☐ No

…dislike certain sensations/textures (e.g. tags on shirts, waistbands? ☐ Yes ☐ No

…flap his/her arms or hands when excited or overwhelmed? ☐ Yes ☐ No

…avoid physical affection from others? ☐ Yes ☐ No

…seek out physical play/stimulation? (e.g. deep pressure, swinging in the air, rough housing, hugs, etc.). ☐ Yes ☐ No

…talk excessively without regard for his/her partner's interest? ☐ Yes ☐ No

…have difficulty tolerating changes to his/her routine? ☐ Yes ☐ No

…put toys/objects in his/her mouth? ☐ Yes ☐ No

Please describe any aversions to textures, temperatures, etc. that your child exhibits.

____

____

____

Does your child have a history of any of the following?

☐ Depression ☐ Physical abuse ☐ Unusual thinking

☐ Mood swings ☐ Sexual abuse ☐ Anxiety

☐ Suicidal thoughts/attempts ☐ Don't know

SOCIAL INFORMATION

Does your child interact with other children? ☐ Yes ☐ No

Describe how your child interacts with other children ________________________________

____

____

How many close friendships does your child currently have? ___________________________

Outside of school/daycare settings, on average, how many times a week does your child have play dates with friends?____

Does your child have any problems getting along with others? ☐ Yes ☐ No

☐ Difficulty making friends ☐ Difficulty keeping friends ☐ Few friends/loner

☐ Competitive with siblings ☐ Plays mainly with younger children ☐ No best friend

☐ Not respectful of authority ☐ Plays mainly with older children

How often is your child teased (e.g. called names, verbally harassed)?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always

How often is your child bullied (e.g. physically harassed, items stole)?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always

Does your child prefer to play alone? ☐ Yes ☐ No

What games and toys does your child prefer? ______________________________

____

Describe how your child plays with toys: ______________________________

____

____

Does your child interact with adults? ☐ Yes ☐ No

Describe how your child interacts with adults: ______________________________

____

____

Has your child experienced any parental separations or the death of any family member?

☐ Yes ☐ No If yes, please describe circumstances (such as child's age or event).

____

____

Is either parent away from home for several days at a time on a regular basis? ☐ Yes ☐ No

Does your cultural heritage play a significant role in your daily life? ☐ Yes ☐ No

Please list any recent stressors, legal issues, or crises that may be affecting the family and/or the child being assessed (e.g. death in the family, divorce, illness, financial difficulties, bullying, custody disputes, recent move, court cases, etc.)______________________________

____

____

Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

☐ Football ☐ Karate ☐ Dance (type)______________

☐ Baseball ☐ Piano ☐ Music (type)______________

☐ Cheerleading ☐ Scouts ☐ Gymnastics

☐ Basketball ☐ Soccer ☐ Other(s): ______________

COMMUNICATION INFORMATION

Check all statements that describe your child's communicative behavior:

Receptive:

☐ Following 1-step directions ☐ Understanding age appropriate vocabulary

☐ Following multiple step directions ☐ Responding correctly to "wh" questions

☐ Understands what you are saying ☐ Able to retrieve common objects upon request

☐ Able to understand age appropriate jokes/idioms (e.g., "That was a piece of cake")

Expressive:

☐ Has not yet started to talk
☐ Was late in starting to talk
☐ Does not talk very much
☐ Uses a lot of gestures
☐ Tries hard and seems to want to communicate
☐ Is able to sequence stories from start to finish
☐ Uses age appropriate vocabulary
☐ Asks questions of others
☐ Able to engage in a conversation (initiating a conversation, maintaining the conversation)

Articulation/Speech:

☐ People have trouble understanding the child
☐ Difficulty with sequencing long words
☐ Is not making speech sounds correctly (age expected)
☐ Has specific sound errors, describe____

Voice:

☐ Pitch level is unusual (e.g., too high, too low)
☐ Speech is too loud or too soft (underline which)
☐ Frequent laryngitis
☐ Has an unusual voice quality (hoarse, harsh, whispery)

Fluency:

☐ Frequently stutters or stammers
☐ Hesitates or repeats sounds and words excessively
☐ Says "um" or "uh" a lot

Please include any further information regarding communicative behavior or elaboration on the above statements can be included here: ____

____

____

____

Does your child have a means to indicate "yes" or "no"? ☐ Yes ☐ No
If yes, please describe: ____

____

____

Do you think your child can understand more than they can say? ☐ Yes ☐ No
If yes, please explain or give an example: ______________________________________

____

____

Do you think your child gets frustrated when he or she cannot communicate effectively?
☐ Yes ☐ No
If yes, please explain or give an example: ______________________________________

____

____

Please mark the statement(s) that would best describe your child's current means of communication:

☐ Crying or tantrums
☐ Body language (e.g., pointing, looking, gesturing)
☐ Sign Language
☐ Pictures
☐ Augmentative device (please describe): ______________________________
☐ Sounds (e.g., vowel sounds, consonant sounds, grunting)
☐ Single words- please list several words used regularly______________________________
☐ 2-4 word sentences- please provide example (s): ______________________________

____

☐ Sentences longer than 4 words- please provide example (s):______________________________

____

☐ Other: ______________________________

____

____

Does your child use their communication to (check all that apply):

☐ Initiate communicative interaction
☐ Comment on the past
☐ Comment on the present
☐ Comment on the future
☐ Respond to questions
☐ Ask questions
☐ Reject non-preferred items
☐ Request people
☐ Request activities
☐ Request objects

Has your child's communication ever been evaluated by a Licensed Speech Language Pathologist? ☐ Yes ☐ No

If your child has recently been evaluated, **please include a recent evaluation report** and summarize the results of the speech and language evaluation in terms of language comprehension, language production and speech production (how he produces his/her sounds): ______________________________

____

____

____

EDUCATIONAL INFORMATION

Please complete for children in school

Is your child currently enrolled in a school or preschool? ☐ Yes ☐ No

School:____ Type: ☐ Public ☐ Private

District:____________________________________ Grade:__________________________

Address: __________________________________City:____________________________

Teacher(s): ____ Phone: _____________

Type of classroom:

☐ Regular/Mainstream/Inclusion

☐ Special Education/Resource

☐ Split Day/Other (Specify)______________________________________

In your child's main classroom setting, what is the number of:

Typically developing students: ____________

Students with special needs: ______________

Teachers: ____________________________

Instructional Aides/Assistants: ____________

Does your child currently receive special education services? ☐ Yes ☐ No
If yes, what age and grade did these start? Age:_____________ Grade: _______________

If yes, under what category did your child qualify for special education?_____________

____

If yes, date of last complete evaluation: ____

Does your child currently receive section 504 accommodations? ☐ Yes ☐ No
If yes, what age and grade did these start? Age: ________________ Grade: ____________

If yes, why did your child qualify for 504 accommodations?____________________________

Does your child have an aide (also known as a SEIT or a paraprofessional)?

☐ One-on-one aide

☐ Shared aide

☐ Classroom wide aide

☐ No aide

Please specify the type of support: ☐ Full time ☐ Part time (# of hrs. ________)

Are you satisfied with the services your child has received at school? ☐ Yes ☐ No
Comments: ____

If your child has an IFSP/IEP in place, please include a copy.

Do you have specific concerns regarding your child's school progress? ☐ Yes ☐ No

☐ Academics ☐ Social ☐ Teacher ☐ Peer relationships

Are your concerns related to achievement? ☐ Yes ☐ No

For: (check all that apply) ☐ Reading ☐ Math ☐ Language

Do you have concerns related to: ☐ Yes ☐ No

☐ Off-task behavior ☐ Organization ☐ Attention ☐ Concentration

Currently or in the past, has your child's teacher discussed any of these problems?

☐ Getting along with peers
☐ Turning in assigned work
☐ Disrupting classroom
☐ Getting along with teachers
☐ Difficulty waiting turn
☐ Excessive socializing
☐ Completing work on time
☐ Following directions
☐ Following rules (classrooms, bus, recess, lunch)
☐ Rushing to complete work
☐ Staying on task during work periods
☐ Making frequent careless errors
☐ Completing large or long-term projects
☐ Organization of work materials
☐ Forgetting to bring homework materials home or to return completed work

Has your child ever experienced any of the following?

☐ Delayed kindergarten entry
☐ Retained in grade __________
☐ In-school suspension, reason____ in grade_____________
☐ Suspended for __________ days, reason________________________________ in grade_____________
☐ Expelled, reason____ in grade_____________

Please describe your child's classroom performance or participation in the classroom (if appropriate):____

____

____

____

What are your child's strengths and/or best subjects? ____

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Services

What services does your child currently receive?

Service Provider (i.e., Speech-Language Pathologist, Occupational Therapist)	**Frequency** (i.e. Twice a week)	**General Goals** (i.e., increase vocabulary, increase fine motor skills, increase articulation)

If your child receives services, please include a recent treatment plan.

What do you enjoy most about raising your child?____

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____

What are your child's main strengths?____

____

____

What are your child's main weaknesses?____

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Thank you for taking the time to complete this form. Please address any additional concerns or comments below:

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