INTAKE PACKET FOR (check all that apply): ☐ **ABA Services** ☐ **Diagnostic Testing** ☐ **Consultation** ☐ **Occupational Therapy** ☐ **Speech Therapy**

CLIENT INFORMATION

Child's Name (Last, First, Middle Initial): Last Name First Name Middle Initial

Gender: Select Date of Birth: Month Day Type Year Age: Type Age Grade: Select

Height: Feet ' Inches" Weight: Enter Lbs.

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: Click here to enter text.
Secondary language spoken at home (if applicable): Click here to enter text.

CONTACT INFORMATION

Name of Person Completing this Form: Click here to enter text.

Relationship to Child: Click here to enter text.

Today's Date: Click here to enter a date.

How did you hear about Holland Center? Click here to enter text.

FAMILY INFORMATION

Mother / Legal Guardian: Click here to enter text. Date of Birth: Month Day Type Year Age: Type Age

Occupation: Click here to enter text. Total Years of Education: Enter

Highest Educational Degree: Enter Daytime Phone: Enter Cell Phone: Enter

Address: Click here to enter text.

E-mail Address(s): Click here to enter text.

RELATIONSHIP: ☐ Biological Parent ☐ Step Parent ☐ Adoptive/Foster Parent ☐ Other: Specify

Father / Legal Guardian: Click here to enter text. Date of Birth: Month Day Type Year Age: Type Age

Occupation: Click here to enter text. Total Years of Education: Enter

Highest Educational Degree: Enter Daytime Phone: Enter Cell Phone: Enter

Address: Click here to enter text.

E-mail Address(s): Click here to enter text.

RELATIONSHIP: ☐ Biological Parent ☐ Step Parent ☐ Adoptive/Foster Parent ☐ Other: Specify

Child lives with (check all that apply): ☐ Father ☐ Mother ☐ Other (specify): Click here to enter text

Parents are: ☐ Married (Number of years: Enter) ☐ Separated (Date: Enter)

☐ Divorced (Date: Enter) ☐ Never Married ☐ Widowed (Date: Enter)

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: Age Location

Siblings:

	Name	Age	Relationship	Living in Home?
1.	Enter Name	Age	Choose an item.	Choose an item.
2.	Enter Name	Age	Choose an item.	Choose an item.
3.	Enter Name	Age	Choose an item.	Choose an item.
4.	Enter Name	Age	Choose an item.	Choose an item.
5.	Enter Name	Age	Choose an item.	Choose an item.

REFERRAL INFORMATION

Primary Physician: Click here to enter text. Phone: Enter

Primary Physician Address: Click here to enter text.

Referring Physician: Click here to enter text. Phone: Enter

Referring Physician Address: Click here to enter text.

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

Primary Insurance:

Policy Holder: Click here to enter text. DOB: Enter Place of Employment: Click here to enter text.

Insurance Carrier: Click here to enter text.

Group #: Enter ID#: Enter Policy #: Enter

Secondary Insurance (if applicable):

Policy Holder: Click here to enter text. DOB: Enter Place of Employment: Click here to enter text.

Insurance Carrier: Click here to enter text.

Group #: Click here to enter text. ID#: Enter Policy #: Enter

Medical Assistance/TEFRA (if applicable):

Policy Holder: Click here to enter text. DOB: Enter Place of Employment: Click here to enter text.

Group #: Enter ID#: Enter Policy #: Enter

*****Please include a copy of all insurance cards (front and back) listed above.*****

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

Click here to enter text.

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

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.

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

Click here to enter text.

Does the child currently have an Autism Spectrum Disorder diagnosis?

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

Who made this diagnosis? Click here to enter text. Date: Enter

Does the child currently have any of the following diagnoses?

	Diagnosed by:	Date
□ Depression	Click here to enter text.	Date
□ Anxiety Disorder	Click here to enter text.	Date
□ ADHD	Click here to enter text.	Date
□ OCD	Click here to enter text.	Date
□ Tourette's Syndrome	Click here to enter text.	Date
□ ODD/Conduct Disorder	Click here to enter text.	Date
□ Learning Disability	Click here to enter text.	Date
□ Intellectual Disability/MR	Click here to enter text.	Date
□ Sensory Integration Disorder (SID)	Click here to enter text.	Date
□ Epilepsy/Seizure Disorder	Click here to enter text.	Date
□ Other	Click here to enter text.	Date

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
Click here to enter text.	Click here to enter text.	Date
Click here to enter text.	Click here to enter text.	Date
Click here to enter text.	Click here to enter text.	Date

******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.

Click here to enter text.

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

Click here to enter text.

PREGNANCY AND BIRTH INFORMATION

The pregnancy was mother's number of number pregnancies with number live births.

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

Were there any difficulties getting pregnant with this child? ☐ 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 child? Number

How many abortions did the biological mother have prior to this child? Number

Did any of the following occur during the pregnancy?

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

Please elaborate on any difficulties experienced during pregnancy. Click here to enter text.

Mother's age at time of delivery: Enter Father's age: Enter

Hospital, city, and state of birth: Click here to enter text.

Did the birth mother receive regular prenatal care? ☐ Yes ☐ No

Length of pregnancy: Enter 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? Click here to enter text.

What drugs were used to assist with labor/delivery? Click here to enter text.

How was the child delivered?

- ☐ Vaginal – Normal Vertex Position (Head First)
- ☐ Vaginal – Breech (Leg or Bottom First)
- ☐ Vaginal – Face First
- ☐ Planned Caesarean Section
- ☐ Emergency Caesarean Section

What was the child's weight at birth? Enter Lbs, Enter oz. Length? Enter In/Cm?

Apgar scores: Enter at 1 minute; Enter at 5 minutes

Child's condition at birth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't know

Length of hospital stay: Infant Enter Mother Enter

Were any of the following experienced during delivery?

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

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. Click here to enter text.

Is there any other information about the mother or baby that may be pertinent? Click here to enter text.

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 (e.g., didn't like to be held, very early interest in numbers)? Click here to enter text.

How was the child fed? ☐ Breast fed until Enter months ☐ Bottle fed ☐ Both

Were there any feeding difficulties? ☐ Yes ☐ No

Did the baby have problems gaining weight? ☐ Yes ☐ No

If yes, please explain:

Click here to enter text.

BIRTH TO ONE YEAR

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

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

ONE TO THREE YEARS

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

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

THREE TO FIVE YEARS

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

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

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

- □ Structured activity
- □ Behavior
- □ Peer relationships
- □ Group activity
- □ Attention
- □ Transitions

At what age did your child first do the following? Please check boxes for skills that have been acquired and indicate the age in months (i.e., such as 16 mo.). If the skill has not yet been acquired, leave this area blank.

- ☐ Smiled: Months
- ☐ Imitated sounds: Months
- ☐ Babbled: Months
- ☐ Said other single words: Months
- ☐ Said "mama" or "dada": Months
- ☐ Followed simple directions: Months
- ☐ Said 2-3 word phrases: Months
- ☐ Knew colors: Months
- ☐ Recited total alphabet: Months
- ☐ Separated easily from mother: Months
- ☐ Drank from an open-faced cup: Months
- ☐ Ate table foods: Months
- ☐ Grasped a Crayon
- ☐ Read words: Months
- ☐ Held head erect: Months
- ☐ Rolled over: Months
- ☐ Sat alone: Months
- ☐ Crawled: Months
- ☐ Walked alone: Months
- ☐ Rode tricycle: Months
- ☐ Dressed self: Months
- ☐ Started counting: Months
- ☐ Tied shoes: Months
- ☐ Fed self with spoon: Months
- ☐ Fed self with utensils: Months
- ☐ Bowel trained: Months
- ☐ Bladder trained: Months
- ☐ Dry at night: Months

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: Click here to enter text.

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

How active is your child? Click here to enter text.

How well does your child deal with transition and change? Click here to enter text.

How well does your child respond to new places, people, and things? Click here to enter text.

How is your child's basic mood (e.g., happy, sad, angry, quiet)? If other, please explain. Click here to enter text.

Is your child predicable in patterns of sleep, appetite, etc.? Click here to enter text.

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

Other serious injuries/surgeries: Click here to enter text.

Hospitalizations (reason)	Dates
Click here to enter text.	Enter
Click here to enter text.	Enter
Click here to enter text.	Enter
Click here to enter text.	Enter

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
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Click here to enter text.

Please list in detail all known allergies (include food, animal, plants/other): Click here to enter text.

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

When was your child's last complete physical? Click here to enter text.

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

If yes, please explain: Click here to enter text.

When was your child's hearing last screened and what were the results? Click here to enter text.

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? Click here to enter text.

******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 GENETIC TESTING REPORTS******

Is your child currently seeing any medical specialists or therapists (i.e., neurology, occupational therapy, speech therapy, or physical therapy)? ☐ Yes ☐ No

If yes, please provide name: Click here to enter text.

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

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

Gross motor coordination (e.g., running, jumping)? ☐ Yes ☐ No

Fine motor coordination (e.g., grasping objects, holding a pencil, fastening buttons)? ☐ Yes ☐ No

Visual motor coordination (e.g., puzzles, cutting on a line)? ☐ Yes ☐ No

Does your child experience any of the following difficulties with sleep? (Select all that apply):

☐ Difficulty falling asleep ☐ Waking in the night ☐ Nightmares

☐ Night terrors ☐ Sleeps too much ☐ Snoring

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

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

☐ Daytime wetting ☐ Toilet refusal ☐ Night wetting

☐ Constipation ☐ Soiling ☐ Diarrhea

☐ Other: Describe

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: Describe

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: Describe

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

If yes, what foods? : Click here to enter text.

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: Click here to enter text.

Do you have any other concerns about your child's current eating habits? Click here to enter text.

BEHAVIORAL INFORMATION

Does your child currently receive any applied behavior analysis (ABA) services? ☐ Yes ☐ No

If yes, what type of services (check all that apply): ☐ Center-Based ☐ Home Program

☐ Other (specify): Enter

Has your child received any ABA services in the past? ☐ Yes ☐ No

If you answered yes to either of the questions above, complete the following:

Provider	Frequency / # of Hours per Week	Date Started	Date Ended / Current	Does a BCBA oversee this program?
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select

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

- ☐ Cooperative/attentive
- ☐ Willing to try new activities
- ☐ Usually happy/easy going
- ☐ Short attention span/restless
- ☐ Destructive/aggressive
- ☐ Difficulty waiting /accepting "no"
- ☐ Problems transitioning to other activities
- ☐ Craves touch
- ☐ Shy/quiet
- ☐ Easily frustrated
- ☐ Tires easily
- ☐ Withdrawn
- ☐ Avoids touch
- ☐ Plays/shares well with others
- ☐ Poor eye contact
- ☐ Repetitive behavior
- ☐ Impulsive/distractible
- ☐ Stubborn/resistant to change
- ☐ Self-abusive behavior
- ☐ Other: Describe

How frequently does your child display each of the following?

Crying/Screaming: Select	Please describe: Describe
Tantrums: Select	Please describe: Describe
Aggressive Behaviors: Select	Please describe (e.g., kicks, punches, etc.): Describe
Self-Injurious Behaviors: Select	Please describe (e.g., hits head, pinches, etc.): Describe
Property Destruction: Select	Please describe (e.g., throws objects, rips materials, etc.): Describe

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:

Click here to enter text.

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

Click here to enter text.

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

- ☐ Head, facial or neck twitches
- ☐ Walks in unusual manner
- ☐ Is generally clumsy
- ☐ Nervous habits, describe: Describe
- ☐ Repetitive actions when excited, describe: Describe
- ☐ Other: Click here to enter text.
- ☐ Problems with balance
- ☐ Walks on tiptoes

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 (e.g., 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)? Click here to enter text.

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

If yes, how so? Click here to enter text.

…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.

Click here to enter text.

Does your child have a history of any of the following (check all that apply)?

- □ Depression
- □ Mood swings
- □ Suicidal thoughts/attempts
- □ Physical abuse
- □ Sexual abuse
- □ Unusual thinking
- □ Anxiety
- □ Don't know

Describe the items and activities that your child enjoys: Click here to enter text.

Identify typical reinforcers in these groups:

Food items: Click here to enter text.

Toys: Click here to enter text.

Praise: Click here to enter text.

Physical Activities: Click here to enter text.

Describe what your child would do if left alone to their own devices for a period of time:

Click here to enter text.

SOCIAL INFORMATION

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

Describe how your child interacts with other children. Click here to enter text.

How many close friendships does your child currently have? Click here to enter text.

Outside of school/daycare settings, on average, how many times a week does your child have play dates with friends? Click here to enter text.

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

Check all that apply:

- □ Difficulty making friends
- □ Difficulty keeping friends
- □ Few friends/loner
- □ Competitive with siblings
- □ Not respectful of authority
- □ No best friend
- □ Plays mainly with older children
- □ Plays mainly with younger children

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

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

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

What games and toys does your child prefer? Click here to enter text.

Describe how your child plays with toys: Describe

Does your child interact with adults? ☐ Yes ☐ No

Describe how your child interacts with adults: Describe

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): Describe

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 treated (e.g., death in the family, divorce, illness, financial difficulties, bullying, custody disputes, recent move, court cases, etc.).

Click here to enter text.

Child's extracurricular activities (e.g., sports, clubs, hobbies, lessons, etc.):

- ☐ Football
- ☐ Baseball
- ☐ Cheerleading
- ☐ Basketball
- ☐ Karate
- ☐ Piano
- ☐ Scouts
- ☐ Soccer
- ☐ Dance (type): Describe
- ☐ Music (type): Describe
- ☐ Gymnastics
- ☐ Other(s): Describe

COMMUNICATION INFORMATION

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

Receptive:

- ☐ Following 1-step directions
- ☐ Following multiple-step directions
- ☐ Understands what you are saying
- ☐ Able to understand age appropriate jokes/idioms (e.g., "That was a piece of cake")
- ☐ Understanding age appropriate vocabulary
- ☐ Responding correctly to "wh" questions
- ☐ Able to retrieve common objects upon request

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 (i.e., initiating a conversation, maintaining the conversation)

Articulation/Speech:

- □ People have trouble understanding the child
- □ Has specific sound errors; Describe
- □ Difficulty with sequencing long words
- □ Is not making age expected speech sounds correctly

Voice:

- □ Pitch level is unusual (e.g., too high, too low)

Speech is ☐ too loud or ☐ too soft

- □ Frequent laryngitis
- □ Has an unusual voice quality (e.g., 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: Click here to enter text.

Does your child have a means to indicate "yes" or "no"? ☐ Yes ☐ No

If yes, please describe: Click here to enter text.

Do you think your child can understand more than they can say? ☐ Yes ☐ No

If yes, please explain or give an example: Click here to enter text.

Do you think your child gets frustrated when he or she cannot communicate effectively? ☐ Yes☐ No

If yes, please explain or give an example: Click here to enter text.

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): Click here to enter text.
- □ Sounds (e.g., vowel sounds, consonant sounds, grunting)
- □ Single words; please list several words used regularly
- □ 2-4 word sentences (please provide examples): Click here to enter text.
- □ Sentences longer than 4 words (please provide examples): Click here to enter text.
- □ Other: Click here to enter text.

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 ******

If your child has recently been evaluated, 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):

Click here to enter text.

EDUCATIONAL INFORMATION

Please complete for children in school

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

School: Click here to enter text. Type: Select

District: Click here to enter text. Grade: Select

Address: Click here to enter text.

Teacher(s): Click here to enter text. Phone: Click here to enter text.

Type of classroom: Choose an item. If other, specify: Click here to enter text.

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

Typically developing students: Number

Students with special needs: Number

Teachers: Number

Instructional Aides/Assistants: Number

Does your child currently receive special education services? ☐ Yes ☐ No

If yes, what age and grade did these start? Age: Type Age Grade: Select

If yes, under what category did your child qualify for special education? Click here to enter text.

If yes, date of last complete evaluation: Click here to enter a date.

Does your child currently receive section 504 accommodations? ☐ Yes ☐ No

If yes, what age and grade did these start? Age: Type Age Grade: Select

If yes, why did your child qualify for 504 accommodations? Click here to enter text.

Does your child have an aide (also known as paraprofessional or teaching assistant)? Choose an item.

Please specify the type of support: Choose an item. Indicate number of hours: Number

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

Comments: Click here to enter text.

******IF YOUR CHILD HAS RECENTLY BEEN EVALUATED OR CURRENTLY RECEIVES SPECIAL EDUCATION SERVICES, PLEASE INCLUDE A RECENT EVALUATION REPORT AND AN IEP OR IFSP ******

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

Indicate the specific concerns you have (check all that apply):

☐ 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 (check all that apply):

☐ Off-task behavior ☐ Organization ☐ Attention ☐ Concentration

Currently or in the past, has your child's teacher discussed any of these problems (check all that apply)?

☐ 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(s): Enter
☐ In-school suspension, reason(s): Click here to enter text.; in grade(s): Enter
☐ Suspended for Enter days, reason(s): Click here to enter text.; in grade(s): Enter
☐ Expelled, reason(s): Click here to enter text.; in grade(s): Enter

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

Click here to enter text.

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

Click here to enter text.

Services

What services does your child currently receive?

Service Provider	**Frequency** (i.e., twice a week)	**General Goals** (i.e., increase vocabulary, increase fine motor skills, increase articulation)
Speech-Language Pathologist	Enter	Click here to enter text.
Occupational Therapist	Enter	Click here to enter text.
Physical Therapist	Enter	Click here to enter text.
Other: Specify	Enter	Click here to enter text.
Other: Specify	Enter	Click here to enter text.
Other: Specify	Enter	Click here to enter text.

******IF YOUR CHILD RECEIVES SERVICES, PLEASE INCLUDE THE MOST RECENT EVALUATION AND TREATMENT PLAN WHEN RETURNING THIS PACKET******

What do you enjoy most about raising your child?

Click here to enter text.

What are your child's main strengths?

Click here to enter text.

What are your child's main weaknesses?

Click here to enter text.

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

Click here to enter text.