



Support Services
Parent Intake Forms

Please fill-out this form as completely as possible. All information is strictly confidential.

Student's Name: _____ Sex: M ____ F ____

Home address: _____ Student Tel #: _____

Date of Birth: _____ Age: ____ Grade: _____ Student Email: _____

School: _____ Referred by: _____

Name of person completing this form: _____ Relationship: _____

Tel #: _____ Your Email: _____

What is your Primary Concern?

When did you begin to become concerned and why?

What is your child's understanding of why you are here today?

What are your child's feelings about coming here?

Has the student ever been tested or received special academic or behavioral help? Yes ____ No ____ If yes, please describe the type of service, the school or agency which rendered service and the dates of the service.

<u>Type of Service</u>	<u>School or Agency</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Parents Names: _____

Cell Phone: _____ Email address: _____

Home Phone: _____ Home address: _____

Name and Ages of Siblings: _____

Any history of learning difficulties? (if yes, please explain) _____



Main Language spoken at home: _____ Other languages spoken: _____

School History List, in order, the schools the student has attended:

SCHOOL	CITY	GRADE LEVEL (S)	DATES

Medical/Developmental History

Pregnancy: How would you describe the pregnancy?

Did the Mother experience any illnesses, accidents, shocks, mental or physical strain, or any other complication during pregnancy? (if yes, please describe) _____

How would you describe the birth? Were there any difficulties or complications? Was the baby full term?

Early Years and Overall Health

What kinds of childhood illnesses did your child have?

Were there any instances of high fevers or convulsions? Were there any head injuries or loss of consciousness?

Has your child ever been on any medications?

Does your child have difficulty sleeping?

Describe your child's appetite. Any food allergies?

Does your child have any coordination problems? If so, explain:

How would you describe your student's overall health?



Please check any of the developmental milestones that came late for your child.

Babbling: _____ Speaking Single Words: _____ 2-3 Word Combinations: _____ Reading: _____ Writing: _____

Social/Emotional History

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

Please describe the student's attitude toward the following:

Brothers and sisters: _____

Friends: _____

Does your child prefer to be alone or with other teens? _____

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

What helps your child feel successful?

Feelings/Attitudes Toward School

What are your child's favorite subjects in school?

What are your child's least favorite subjects?

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

About how many days a year is your child absent from school? _____

Anything else I should know about your child?



AUTHORIZATION TO RELEASE INFORMATION

By my signature below, I hereby authorize **Nancy R. Melrose** and other educational or therapeutic professionals who work with the student below to discuss pertinent information and/or testing for the purpose of better serving this student. These professionals may include but are not limited to the student's advisor, teachers, therapist, psychologist or pediatrician. I understand that any information disclosed will be strictly confidential and used solely for the purposes of providing educational therapy.

I understand that I may at any time withdraw permission to share the student's information with educational or therapeutic professions, either jointly or severally at any time, by writing a letter to **Nancy R. Melrose**.

Name of Student: _____ Date of Birth: _____

Parent Guardian Print

Parent Guardian Signature

Date