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's Name: _____

Relationship to Student:_____ Email _____

Phone: H _____ W _____ C_____

Occupation: Mother_____ Father _____ Guardian_____

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?_____

_____

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

_____

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

_____

_____

Indicate any label/disorder that has been used to describe your child: Is this a formal diagnosis? ☐Yes ☐No

☐ADD	☐Autism	☐Learning Disability	☐Dyslexia/Reading Problem
☐ADHD	☐PDD	☐Speech/Language Delay	☐Auditory Processing Disorder
☐Asperger	☐Anxiety	☐Color Blindness	☐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 Reason_____

Chino Office - 15192 Central Avenue, Chino, California 91710 P (909) 598-2482 F (909) 598-3442
Irvine Office - 1150 Main St, Ste C, Irvine, CA 92614 P (949) 447-4133 F (949) 477-4082
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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 for the above problems:

_____

_____

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

_____

Are there difficulties completing homework? _____ Please describe: _____

_____

_____

Is there a family history of learning difficulties or challenges in school? Briefly describe. _____

_____

_____

Medical History

Birth was: ☐Premature ☐Late ☐Normal ☐Vaginal ☐Caesarian Birth weight _____

Complications in pregnancy or delivery? _____

_____

Is your child currently under a doctor's care or on any medication? _____

Reason _____

Current medications _____

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

_____

_____

_____

Would you like a copy of the assessment results sent to your child's teacher? ☐Yes ☐No

Teacher's name and address:_____

_____

Would you like a copy of the assessment results sent to your child's doctor? ☐Yes ☐No

Doctor's name and address:_____

_____

How did you hear about us?/Who may we thank for referring you? (Please include address) _____

_____

Parent/Guardian Signature	Relationship to child	Date

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