S.E.E.DS. of the Willistons Inc.

129A Hillside Avenue ● Williston Park, NY 11596 ● (516) 742-5243

By completing all requested information, we will be able to service your needs better.

All information provided will kept in strict confidence

For Office Use Only:

Evaluation Date and Time_____ Therapist_____

SUMMER PROGRAM
INTAKE FORM

Identifying Information

Client's Full Name: _____ Today's Date_____

Date of Birth:_____Chronological Age (years and months)_____

Address: _____

State/Zip Code: _____ Home Phone_____

PARENT/GUARDIAN E-MAIL ADDRESS:

_____@_____

Do you wish for us to correspond with you via email? ____YES ____NO

Referred by:_____ Affiliation_____

Reason for referral: please describe the concerns you have regarding your child's speech/language/social skills?_____

_____

_____

When was this problem first noticed and by whom? _____

_____

Family Information

Mother's Name:_____ Languages Spoken: _____

Address (if different from Client):_____

Occupation: _____Education Level: _____

Business Phone: _____Cell Phone: _____

Home Phone (if different from client)_____

Email Address (*If different from the one provided on page one*)_____

Father's Name: _____Languages Spoken:_____

Address (if different from client)_____

Occupation:_____ Education Level:_____

Business Phone: _____Cell Phone: _____

Home Phone: (if different from client)_____

Email Address: (*If different from the one provided on page one)*_____

Names and ages of siblings:

Name	Age	Sex	peech/language Problem	Remarks

Is there any other familial history of speech/language or learning problems?

_____

_____

Medical History

Physician _____Phone #: _____

Address:_____Discipline:_____

Has your child been diagnosed with any learning disability?? ____YES ____NO

If so, please describe his/her diagnosis:_____

Does your child have any known allergies? _____ If so, to what?

_____

Does your child take any medication? _____ if yes, please list name, strength, frequency and for what condition._____

Has your child ever been evaluated or treated by any of the following medical specialists:
Audiologist _____Psychologist_____Orthodontist____ Neurologist_____ Physcial Therapist_____Occupational Therapist_____ Otolaryngologist(ENT)_____ Other (specify)_____

Specialist Name: _____Phone: _____
Address: _____Specialty: _____
Date(s) Seen: _____Reason_____

Specialist Name: _____Phone: _____
Address: _____Specialty: _____
Date(s) Seen: _____Reason_____

******Please provide copies of any reports that contain relevant information that would assist in assessing your child*****(I.E. – School Report Cards, Prior Evaluation Reports, etc.)**

Who does your child prefer to play with? (Circle ones that apply)

Parents Siblings Peers Younger children Older Children Adults

How does your child interact with others? _____

_____

_____

Please check the behaviors that you feel best describe your child. (circle all that apply)

Overly Active	Overly Quiet	Excessive Tantrums	Destructive
Very Shy	Perfectionist	Friendly, Outgoing	Plays well with peers
Prefers Younger Childr	Able to maintain interactions	Uses Eye Contact	Defiant
Easily Controlled or Passive	Dependent upon Routines	Difficulty Separating from Parents	Nervous
Flexible	Imaginative and Creative	Initiates Interaction	Easily Distracted

How does your child interact with other children?_____

Educational History

Grade Completed as of June 2013_____

Please list all educational programs your child attended. (including early intervention, and preschool)

Name of School	Town/City	Grade Level	Type (Reg./ Spec. Ed)	Dates

How is your child doing academically or pre-academically? _____

_____

Does your child have reading problems?_____Explain_____

_____

What are your concerns with your child?_____

_____

_____

Informant for Case History

_____ _____

Name of Person Completing this form Relationship to Client

_____ _____

Signature of Above Person Date