EduKate, LLC
Educational Therapy

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PARENT INTAKE INFORMATION

NAME OF STUDENT: **BIRTH DATE:**

HOME ADDRESS: **HOME PHONE:**

CELL PHONE:
STUDENT'S PHONE:

PARENT'S E-MAIL: **STUDENT'S E-MAIL:**

CURRENT SCHOOL/ ADDRESS: **PRESENT GRADE:**

REFERRAL SOURCE:

Areas of strengths and expertise (able to do, hobbies, interests):

Areas of concern (needs to learn, difficult subjects or classes, behavior):

What is your primary concern?

What do you hope is achieved through your child receiving educational therapy sessions?

How many days/ wk. does the student receive instructional support in this particular area?	How many minutes long is this instruction per day/ per week?

Student's feeling and attitude toward school (least/favorite subjects):

Previous or current support services and outcomes (private agencies, psychologists, other related service providers, ETs, tutors):

Previous or current 504, special education services, or academic interventions (IEP, RTI, ESL, G&T, etc.):

Accommodations and/or modifications that have been tried or implemented:

Please list approaches that you feel are/ were successful and/or unsuccessful?

SCHOOL HISTORY (including locations)

Preschool:

Elementary School:

Middle School:

High School:

Current teacher/ contact person at school:

Has the student ever repeated or skipped a grade?

Attendance rate (please include number of tardies and/or missed days of school this and the previous school year, reason for absence, etc.)?

Post-secondary goals (e.g., what does your child want to be/do after high school?):

PSYCHOEDUCATIONAL EVALUATIONS/OTHER ASSESSMENTS

Date of Assessment	Reason for Assessment:	By Whom:
Date of Assessment	Reason for Assessment:	By Whom:
Date of Assessment	Reason for Assessment:	By Whom:

MEDICAL HISTORY

Pregnancy was ___easy ___average ___ difficult

Conditions at birth:

Duration of labor:

Type of delivery:

Childhood illnesses:

Childhood hospitalizations:

Hearing:

Vision:

Allergies (food, seasonal, etc.):

Medications administered daily (for asthmas, allergies, diabetes, ADHD, etc.):

Child is current on required/ rec. immunizations for age (circle one): Yes/ No

Thoughts of self-harm or suicide:

Difficulties sleeping and/or awakening:

Pediatrician:

Address

Phone Number

DEVELOPMENTAL MILESTONES

At what age did your child:

Turn over-

Sit-

Walk alone-

Begin feeding self-

Sleep through the night-

Toilet train-

Say single words-

Say sentences-

Was there contact with a foreign language?

Was a hand preference shown?

Can your child:

__Ride a bike

__Skate

__Skip

__Swim

__Throw and catch a ball

EXECUTIVE FUNCTIONING/ BEHAVIORAL OBSERVATIONS

Which behaviors apply to your child under what conditions?

Fidgety when:

Avoids work when:

Withdrawn when:

Cheerful when:

Confident when:

Easily frustrated when:

Attentional difficulties when:

Forgetful when:

Talkative when:

Memory difficulties when:

Disorganized when:

Poor sense of time when:

Motivated to please when:

What helps your child feel successful?

Is your child an easy or difficult child to care for?

Any mental health/ related concerns?

FAMILY CONTACT INFORMATION

Student lives with: ___Mother ___Father ___Both ___Other _____

Is the child adopted?

Other family members or relatives, if any, with learning disabilities or concerns (please specify):

MOTHER/ STEPMOTHER/ GUARDIAN'S NAME: Occupation/ Employer: Address: Phone/ Mobile: E-mail:
FATHER/ STEPFATHER/ GUARDIAN'S NAME: Occupation/ Employer: Address: Phone/ Mobile: E-mail:
Siblings (in order of birth): Name Sex Age Describe student's relationship with each other _____ _____ _____