promOTing particip**A**Tion, LLC & Communication Foundations, LLC
Intake for Group Services

Group of Interest:_____Date: _____

General Information

Child's Name: _____Nickname:_____

DOB: ____/____/_____ Age: _____

StreetAddress: _____

City:_____ Zip:_____

Parent Name(s): _____

HomePhone:_____

Cell Phone: _____ Email

Address:_____

Emergency Contact Person/Relationship:

_____

Phone Number: _____

Child's Primary Care Physician (name, phone):

_____

Referred by (name, organization): _____

Previous/Current Services

School based services:School District _____ School Building _____ 504 IEP None

SLP hrs/week _____ OT hrs/week _____ Social work hrs/wk _____

Spec Ed. hrs/week _____ PT hrs/week _____ BCBA/ABA hrs/wk _____

Private Services: Provider/agency name _____

SLP hrs/week _____ OT hrs/wk _____ PT hrs/wk _____ BCBA/ABA hrs/ wk _____

Medical Information

Does your child have a formal diagnosis? If yes, please list:

_____

_____

Has your child had/have any of the following? If yes, please describe and/or give dates if possible

Serious injury:

_____

_____

Allergies:

_____

_____

Seizures: Yes No If Yes, please list date and description:

_____

_____

Behavioral Concerns:

_____

_

_____

_

_____

_

Other:

_____

_____

Please list any medications that your child is currently taking and frequency of dosage:

_____

_____

Are there any medical precautions that the clinician should be aware of when working with your child? Yes No
If yes, please describe:

_____

_____

_____

Group Information

Has your child participated in this type of group or any formal group before? If yes, please describe type of group and dates attended:

_____

_____
_____
_____

What goals do you and/or your child hope to achieve over the next 8 weeks from participating in this group?

_____
_____
_____
_____