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# CLIENT INTAKE FORM FOR CHILDREN & OLDER STUDENTS

(Please Print)

Today's date:			Person Completing Form:			
CLIENT INFORMATION						
Client's Last name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address		City	State and Zip Code		Client's Birth date / /	Age Gender <input type="checkbox"/> M <input type="checkbox"/> F
Client's School	School District in which Client Resides	Highest Grade Completed		Current Grade	Grades Retained	
CLIENT'S MOTHER'S INFORMATION						
Mother's Name		Mother's Address if Different from Client's		Mother's Home Phone	Mother's Business Phone	
Mother's Cell Phone		Mother's Email Address		Mother's Date of Birth	Mother's Marital Status Single / Mar / Div / Sep / Wid	
Mother's Education		Mother's Employer		Mother's Work Hours	Mother's Position	
CLIENT'S FATHER'S INFORMATION						
Father's Name		Father's Address if Different from Client's		Father's Home Phone	Father's Business Phone	
Father's Cell Phone		Father's Email Address		Father's Date of Birth	Father's Marital Status Single / Mar / Div / Sep / Wid	
Father's Education		Father's Employer		Father's Work Hours	Father's Position	
OTHER INDIVIDUALS LIVING IN THE HOME						
Name	Relationship to Client		Age		Grade	
Referred by:						
Other family members seen here:						

# CLIENT MEDICAL HISTORY

(Please Print)

Client Name:		Person Completing Form:				
Were there any problems during the pregnancy, labor or delivery for this person?	YES	NO	If YES, please describe below:			
Did this person achieve developmental milestones within normal time frames?	YES	NO	If NO, please explain below:			
Adverse reactions to vaccines?	YES	NO	If YES, please describe below:			
Any bouts of strep infection	YES	NO	If YES, any tics or OCD behaviors following strep? Please explain below:			
Any ear infections?	YES	NO	If YES, please answer the following questions:			
Broad spectrum antibiotics used:						
Myringotomy (tubes)? If yes, dates:						
Hearing loss? Explain:						
Prior diagnosis of seizures/epilepsy	YES	NO	If YES, in connection with high fever?	YES	NO	Treatment history epilepsy:
Any Allergies?	YES	NO	If yes, allergic to what?			
Prior diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or ADD?	YES	NO	If YES, describe treatment:			
Current medications & dosages:						

# CLIENT EDUCATIONAL HISTORY

(Please Print)

Client Name:		Person Completing Form:		
Did this person have any developmental delays requiring <b>early intervention</b> ?	YES	NO	If YES, please describe below:	
Did this person require any of the following related services?			What services were provided and when?	
Speech and/or Language Therapy	Yes	NO		
Occupational Therapy	Yes	NO		
Physical Therapy	Yes	NO		
Social Skills Training	Yes	NO		
List all Schools Attended	From	To	Grades	List any special education or remedial services provided
Is English this person's <i>second</i> language?	YES	NO	If YES, what is this person's first language?	
What language is spoken in the home?				
Was this student ever retained? If yes, explain.				
List all <b>Private Services</b> Provided (for example, private tutoring, private OT or PT, private Speech/Language, test preparation courses, etc)				
Service Provided	From	To	Grades	
Favorite Subjects in School				Worst Subjects in School
Corrective lenses for vision?	YES	NO	Vision Therapy? If YES, please explain:	
Hearing aides or FM system?	YES	NO		