

Independent Educational Evaluators of America, LLC

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 early intervention ?		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 Private Services 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			