Dr. Nicole Nicholson Educational Therapy and Educational Psychology

AET/P #2342

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INTAKE FORM

The information provided below is confidential. Please complete the form to the best of your ability.

Child's Name:_____ D.O.B.:_____
Gender:_____Age:_____Grade:_____

School:_____

Parent/Guardian Information (for minor clients):

Parent(s)/Guardian(s):_____

Occupation:_____Home telephone:_____

Work telephone:_____ Cell:_____

Email: _____

Mailing
Address:_____City:_____

State:_____ Zip Code:_____

Additional Parent/Guardian (if information differs from above):

Parent(s)/Guardian(s):_____

Occupation:_____ Home telephone:_____

Work telephone:_____ Cell:_____

Email: _____

Mailing
Address:_____City:_____
_____ State:_____ Zip Code:_____

Name of person completing form:_____

Relation to the client: _____

How did you find out about Dr. Nicholson?:_____

What are your goals for educational therapy? What would you like to accomplish? How can Dr. Nicholson help?

ACADEMIC HISTORY

Present School:_____Grade:_____

Describe any challenges, interventions attempted, and results.

Previous Schools and Years of Attendance

School #2:_____ Years:_____

Describe any challenges that occurred while attending this school, interventions attempted, and results.

School #3:_____ Years:_____

Describe any challenges that occurred while attending this school, interventions attempted, and results.

School #4:_____ Years:_____

Describe any challenges that occurred while attending this school, interventions attempted, and results.

School #5:_____ Years:_____

Describe any challenges that occurred while attending this school, interventions attempted, and results.

BIRTH, MEDICAL and TESTING HISTORY

1. Please describe any complications or special circumstances surrounding birth.

2. Did your child experience a delay, meet, or exceed projected milestones for motor skills, social skills, and speech/language? Describe any challenges in these areas.

3. Has there been a history of ear infections? If so, please describe.

4. Date of last hearing exam: _____Results:_____

5. Does the client wear eyeglasses or contacts? _____ If so, please state reason:

6. Date and Results of last vision exam. Results:_____

6. Has your child taking (or ever taken) any medication? For what purpose?

7. Has your child ever had a head injury? When? How serious? Hospitalized?

8. Please list any previous testing or evaluations done either by school districts, colleges, psychologists, speech pathologists, educational therapists, etc. (please include copies of any assessment results/reports, IEPs, or 504 plans)

9. Please list any psychologists, speech pathologists, LMFTs, educational therapists, tutors or others who have provided services for your child. Describe the nature of the therapy/tutoring and the duration.

11. Describe your child's sleeping patterns, both weekday and weekend.

12. Describe your child's diet. Please state if he/she is on a special diet and for what reason (ex: allergies, diabetes, etc.).

13. Does your child have any chores, at-home jobs or a part-time job he/she is responsible for on a regular basis? If so, please describe below:

SCHOOL/LEARNING EXPERIENCES

14. Has your child been homeschooled, attended a non-traditional school, repeated a grade or dropped out of school? Please explain.

15. Describe your child's strengths and areas of interest.

16. Is your child physically active? If so, how often and in what activities do they engage?

17. Describe your child's challenges.

18. How does your child feel about school? What are his/her favorite and/or least favorite things about school?

19. How does your child relate to peers? Does your child have many friends, prefer older or younger friends? or have difficulty establishing and maintaining friendships?

20. How does your child deal with transitions to new situations such as embarking on a new school year or trying a new and unfamiliar activity?

21. Is there a particular subject area that your child enjoys, shows advanced or above grade level ability?

22. Has your child ever skipped a grade or done a subject level acceleration in an academic content area?

23. Does your child struggle with any of the following areas? Please check all that apply.

- ❏ Speech
- ❏ Reading
- ❏ Writing
- ❏ Spelling
- ❏ Mathematics
- ❏ Mental Health
    - ❏ Mood swings
    - ❏ Depression
    - ❏ Anxiety
    - ❏ Anger
    - ❏ Emotional regulation
- ❏ Behavior
    - ❏ Following directions
    - ❏ Transitioning from task (or activity) to task
    - ❏ Tantrums or acting out
    - ❏ Other
- ❏ Social Skills
    - ❏ Difficulty interacting with staff and/or peers
    - ❏ Engaging in conversations with others
    - ❏ Making (and keeping) friends
    - ❏ Other:
- ❏ Executive Functioning
    - ❏ Organization
    - ❏ Planning
    - ❏ Time Management
    - ❏ Attention
    - ❏ Critical Thinking

Please provide specific details below of any of the difficulties you marked above.

24. Do you have other concerns about your child's school life and academic performance that have not been shared above?

FAMILY BACKGROUND

25. List brothers and sisters with birth dates and any relevant educational information.

26. Has anyone in your family had difficulty learning or been diagnosed with a learning disability or other exceptionality? Please provide relevant information.

27. Has anyone in your family qualified for a Gifted and Talented Program or skipped a grade in school?

28. Parents' education and occupations:

ADDITIONAL INFORMATION

29. Is there anything else about your child's strengths that you would like to share. This information is vital! I build on strengths to address the needs. :)

*Parent/Guardian Signature:_____

*Parent/Guardian Signature:_____

Note: <u>All</u> parents/guardians must consent to the provision of educational therapy to their children.