Pathways to Success for all Learners

Intake Questionnaire

Please Print Today's Date:

Student's Name:

Date of Birth: Age: Grade:

Parent's/Guardian's Name:

Home Address 1: street city state zip

Home Address 2: street city state zip

Contact Information:	Parent 1:	Parent 2:	Student:
Home phone:			
Work phone:			
Cell Phone:			
e-mail:			

Student's School:

School Address: street city state zip

School Contact :

Name: Position:

School Phone Number: Contact's e-mail

Emergency Contact:

Name: Relationship:

Home Phone: Work Phone:

Cell phone: Email:

Insurance Company: Subscriber: Group#:

** Direct payment is requested even though neuropsychological testing and psychotherapy are often partially covered by insurance.*

Please describe the reason for this referral. How can we help?

How did you hear about ILD?

I understand that Payment is due at the time of each visit.

Signature: Date:

ILD has a non-profit partner! ***Research ILD*** *is dedicated to research and development of innovative techniques for helping students learn how to learn.* ***Research ILD*** *also trains educators to appreciate and maximize students' unique learning style.* ***www.researchild.org****.*

4 Militia Drive, Suite 20, Lexington, MA tel:781.861.3711 fax:781.861.3701

Background Learning

Please list the schools your child has attended, beginning with preschool.	
School	Grades

History

In which grade(s) were difficulties/problems evident in these areas?			
	Onset	Duration	Current? Y or N
Attention			
Behavior			
Pencil Control			
Fine Motor Coordination			
Perceptual-Motor Coordination			
Language			
Organization			
Directionality: *right vs. left*			
Memory			
Reading			
Writing			
Spelling			
Math			
Following Directions			
Homework			

Please comment on any areas of learning difficulty checked above:

____
____
____
____

Please describe any other learning problems, noting onset, duration, and current status:

____
____

Current Academic Overview

From your point of view, please rate your child in the following areas:

	Strong	Average	Weak	Previously Weak
Reading words: Decoding				
Reading Comprehension				
Spelling				
Handwriting				
Expressing ideas in writing				
Remembering math facts				
Math Computation				
Solving math word problems				
Paying attention in class				
Keeping materials organized				
Completing homework				
Approaching everyday problems in an organized fashion				
Remaining attentive and focused: *ability to ignore distractions*				
Distinguishing between main ideas and details				
Shifting gears when task so demands				
Explaining ideas clearly				
Integrating new information				
Test performance				

Please describe your child's current school situation:

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Homework

How much time does your child spend on homework each night?					
Does your child usually know his/her assignments?				Yes	No
Does your child bring home the necessary materials to complete assignments?				Yes	No
Does your child usually understand his/her assignments?				Yes	No
How often do you provide homework assistance?	*Every Night*	*Several times per week*	*Once per week*	*Less often*	*Never*

Does Assistance Involve:	
Explaining assignments	Doing assignments with your child
Checking assignments	Time Management
Other:	

Does your child need assistance with multi-step and/or long term assignments? *e.g. book reports, research projects, studying for tests, etc.*
Please describe:

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____
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____

Are homework times stressful for your child?
Please explain:

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Are homework times stressful for you?
Please explain:

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Evaluation/Service History

Has your child been previously evaluated? Yes No
If so, when and where?
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____

Diagnosis:			
No specific diagnosis		Learning Disability	
ADD		ADHD	
Speech/Language disability		Adjustment Disorder	
Anxiety		Depression	
Other:			

Is your child currently on a:

Individualized Education Plan (IEP) Yes No

504 Plan Yes No

Other? *Please explain* :
____

Is your child currently receiving special services? Yes No

What services were instituted?	***How often?***	***Purpose:***	***Dates of service:***
In School:			
Resource room			
In class support			
Other			
At Home:			
Tutoring			
Counseling			
Other			

Were /are these services helpful? Yes No
Please explain:
____
____
____
____
____

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Is your child currently seeing a counselor/ therapist? Yes No
Name_______________________________________ _____________________________________
Telephone______________________________email_____________________________________

Was your child in counseling /therapy in the past? Yes No
When? ________________With whom?____
Reason:____
____

Family History

Mother's Name:		Age:	Occupation:
Father's Name:		Age:	Occupation:
Legal Guardian(s):			Relationship:
Child was adopted Yes No		Parents are Divorced Yes No	
Parents are separated Yes No		Parent(s) deceased Yes No	
Child lives mainly with:			

Siblings:

Name	Age	Grade	Step-Sibling	Adopted	Living at home

Have any family members or relatives had any history of or shown evidence of school difficulties or learning problems (*e.g. dropped out of school, repeated a grade, history of poor grades, attentional difficulties*)? *Please explain:*
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Have any family members or relatives had a history of or shown evidence of social or emotional problems *(e.g. anxiety disorders, depression, schizophrenia, substance abuse, alcoholism, obsessive compulsive disorder, physical/sexual abuse)? Please explain:*
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____
____

Please describe any recent or current family stress *(e.g. unemployment, health problems, losses, changes in work schedules, chronic conflicts, etc.).*

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Medical History

Pregnancy:
Full Term? Yes No other: ____
Problems during pregnancy:

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Delivery:
Please describe complication, if any:

____
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Infancy:
Please describe your child as an infant *(eating/sleeping habits, activity level, sociability, temperament)*:

____
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____
____

Toddler years:
Please describe your child as a toddler *(eating/sleeping habits, activity level, sociability, temperament)*:

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____
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Name of Pediatrician:_____________________________________ ______________________
Telephone:_____________________________email:_____________________________________
Address:____
____

Has your child had routine health examinations? Yes No

Has your child had routine eye and ear examinations? Yes No

Health History:				
	Age of Onset	Duration	Current Condition Y or N	Additional Comments
Colic				
Frequent ear infections Tubes Y or N				
Visual problems				
Hearing problems				
Sleeping problems				
Allergies				
Asthma				
High fevers				
Headaches				
Bedwetting				
Emotional problems				
Seizures				
Surgery				
Hospitalization				

Is your child currently taking any medication(s)? Yes No
Name of medication(s) and dosage:

____
____
____

Who prescribed the medication(s)?___________________________When?__________
Reason(s):____
____

Side effects or concerns about the medication(s):

____
____

Please list any medications that your child has taken in the past:

____
____
____

Please describe any past or current health issues *(e.g. recurrent ear infections, stomach aches, migraine headaches, asthma, diabetes, surgery, etc.).* Note if any of these conditions have resulted in prolonged isolation or school absences.

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Developmental Milestones

	Advanced	Normal	Delayed	Additional Comments:
Sat up without help				
Crawled				
Walked alone				
Rode a bicycle				
Cut with scissors				
Spoke first words				
Spoke in short sentences				
Spoke clearly to others				
Toilet trained				
Dressed self				
Separated easily				

Please mention any other areas in development in which your child was delayed or about which you had/have concerns:

____
____
____
____

Please check any phrases that describe your child:			
Fidgets or squirms when seated		Loses Things	
Has difficulty sustaining attention		Easily distracted	
Has difficulty awaiting turn		Talks excessively	
Fails to complete tasks and or activities		Worries Often	
Blurts out answers or intrudes in conversations		More physically active then other children	
Does not seem to listen to what is being said		Engages in physically dangerous activities	

Have you noticed any of the following behaviors:	
Ticks *(blinking, throat clearing)*	
Oversensitivity to: light, sound , textures, food	
Repetitive behaviors (*hand/arm flapping, hand washing, gestures, checking, re-doing, counting)*	
Articulation difficulties	

Social and Personal Factors

Please check the words or phrases that you feel best describe your child:			
Accepts rules easily		Has many friends	
Affectionate		Has temper tantrums	
Athletic		Impulsive	
Can work well in things he/she really enjoys		Is a loner	
Clumsy		Leader	
Daydreams		Loses friends easily	
Excessive demands for adult attention		Moody	
Excitable		Restless	
Friendly		Will not follow leader in games	
Gets picked on		Attentional problems	
Happy		Has trouble with transitions	

Please describe any behavior that is a problem to parents:

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____

How do you discipline your child?

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What responsibilities does your child have *(chores, jobs, etc)*?

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What are your child's strengths (personality, social, sports, art, music, etc)?

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What are your child's favorite activities?

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How does your child spend time at home?

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Does your child display any excessive fears or worries, if so, what are they?

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____

Are you able to reassure your child when she/ he is fearful or worried? What is most effective?

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____
____

How many hours of television/video games does your child watch or play per week?

____

Has this been an area of conflict or negotiation? Yes No

Does your child get along with classmates? Yes No

Does your child have friends with whom she/he socializes with outside of school? If so, describe the setting and frequency:

____
____
____

Describe any concerns that you have in the area of friendship and behavior:

____
____
____

Would you be interested in a social skills group for your child? Yes No

Does your child prefer playing alone, with friends, or with siblings?

____

Does your child enjoy being read to or independent reading?

____

What is your child's schedule for after school activities?

Monday____
Tuesday____
Wednesday____
Thursday____
Friday____
Saturday____
Sunday____

What does your child perceive as her/his strengths and difficulties?
In academic areas:
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With friends:
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In extracurricular activities:
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With hobbies:
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Additional comments or observations: please feel free to attach additional paper if needed
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For ILD Use Only

Hypothesis:

Persons to be called:

Tests to be administered: