Milestones in the Making
Schiavoni & Associates, Inc.

Intake Form

PLEASE INDICATE WHICH SERVICE YOU ARE REQUESTING:

_____ *Evaluation,* **Lisa Schiavoni,** _____Evaluation, **Yulia Tamayo,** OR
_____ *Coaching/Counseling,* **Brianna Schiavoni**

Date: ____/_____/_____ **Referral Source: _____**
Previously Evaluated by Lisa Schiavoni? _____ If so, when? _____

Custodial Parent: [ ] Mother [ ] Father [ ] Adoptive [ ] Single [ ] Married [ ] Divorced [ ] Separated
If Divorced or Separated, please specify who has custody _____

Child's Name: _____ Nickname: _____ DOB: ____/____/____

School: _____ Grade Level: _____ Age: _____

Parent: _____
Address: _____
_____
Home Telephone: _____
Occupation: _____
Employed By: _____
Work Telephone: _____
Cell Phone: _____
Email: _____

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Address: _____
_____
Home Telephone: _____
Occupation: _____
Employed By: _____
Work Telephone: _____
Cell Phone: _____
Email: _____

Best time & venue for contact? _____

Is your child enrolled in Special Education [ ] YES [ ] NO If so, for which subjects: _____
Does your child have an IEP in place? [ ] YES [ ] NO _____
Does your child have a 504 Plan? [ ] YES [ ] NO _____
***Please provide this office with a copy of your child's IEP &/or 504 Plan at your earliest convenience.*

Does your child attend After-School Care? [ ] YES [ ] NO
Participate in Extracurricular Activities? [ ] YES [ ] NO
Please complete the following schedule to outline any ***scheduling conflicts*** *resulting from after-school activities:*
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Have you had any Parent-Teacher Conferences or Meetings with the school this year? [ ] YES [ ] NO
When? ____/____/____ What was the meeting intended for? _____
_____

School History:

School Name	Grades Attended

What kinds of Grades does your child make in school now? _____
What kinds of Grades do you expect your child to make? _____
Which Subjects are most challenging for your child? (E.g. Math, Reading) _____
_____
In which Subject(s) does your child do best? _____

On average, how much time does your child spend on homework each night? _____
Does your child have a homework routine? [ ] YES [ ] NO If so, please explain: _____

Medical History:
Who is your child's Pediatrician? _____
Please note any Medical Concerns &/or Medical Conditions that may affect your child's social, emotional, cognitive &/or behavioral self? _____

Does your child take medication for any of the conditions listed above? [ ] YES [ ] NO
List of medications: _____

Has your child had a recent Hearing Screening? [ ] YES [ ] NO **Vision Screening? [ ] YES [ ] NO

Please complete the following table so that our office can provide the most comprehensive care possible:

Service	Provider Name	Past or Present? Date Last Seen?
Educational Evaluation		
Speech & Language Therapy		
Occupational Therapy		
Physical Therapy		
Mental Health Counseling		
Tutoring		

Other Useful Information: (please respond to the following prompts for best practice)

(1) Your child's behavior at school (as reported to you)? _____

(2) Behavior at home? _____

(3) Ways in which you punish your child's 'bad' behavior at home? _____

(4) Number one reason your child gets into trouble? _____

(5) Does your child make friends easily? [ ] YES [ ] NO

(6) Do you have any concerns for your child's ability to socialize with his/her peers? [ ] YES [ ] NO
If yes, please explain: _____

(7) Child's interests/hobbies? _____

(8) Your goals for our staff's work with your child? _____

(9) Words used by your family to discuss Child's challenges (e.g. ADHD, laziness, impulsive, depression): _____