Stepping Stones CONSULTANTS

Intake Form

Personal Information:

Child's Name: _____

DOB: _____ Age: _____

Address (include postal code):

Mother's Name: _____ Phone #: _____

Father's Name: _____ Phone #: _____

Email: _____

Medical History:

Primary diagnosis: _____

Secondary diagnosis (if applicable): _____

Age at diagnosis: _____

Current medication (if applicable): _____

_____

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Description of current or past interventions:

In-home program:

Type of programming: _____

Past Consultant(s) (if applicable): _____

Current Consultant(s) (if applicable): _____

Pre-school:

Dates attended: _____

If still attending, how many hours per week? _____

Describe behaviours that teachers have reported occur in a teaching setting and the strategies used to address them (e.g. difficulty sitting during circle time, difficulty playing with others, need support eating, etc.)

_____

_____

_____

_____

_____

Therapies:

Occupational therapy? (Y/N): _____

If yes, hours per week: _____

Goals: _____

_____

Who provides OT service? _____

Physical therapy? (Y/N): _____

If yes, hours per week: _____

Goals: _____

_____

Who provides PT service? _____

Speech and Language therapy? (Y/N): _____

If yes, hours per week: _____

Goals: _____

_____

Who provides SLP service? _____

General information about your child:

Describe how your child communicates (e.g. vocalizations, words, sign language, PECS, etc.), including how they make requests.

Describe how your child reacts when they get upset and what can trigger them.

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Is your child toilet trained? (Y/N): _____

Does your child have significant eating issues? (Y/N): _____

If yes, please describe:

_____

Does your child have significant sleeping issues? (Y/N): _____

If yes, please describe: _____

Primary Goals:

Please list your three major goals for your child over the next year:

_____

_____

_____

_____

_____