Special Services Intake Form

Date: _____ School: _____

ID# _____ Grade: _____

The following information is considered confidential. Please answer all questions as well as you can.

Identifying Information		
Child's name:		
Date of birth and current age:	DOB:	Age:
Gender and race:	Gender:	Race:
Person completing form:	Name:	Do you have legal custody? Yes No
Family Information		
Home Address	Street Address:	Apt/lot#:
	City: State:	Zip Code:
	County:	
Phone number(s) and email address:	Home:	Cell:
	Work:	Email Address:
Biological Parents or Guardian Information		
Parent/Guardian Female Name: _____ Relationship: □ Biological Mother □ Step-Mother □ Adoptive Mother □ Grandmother □ Other Relative □ Unrelated	Age:____Education:_____Occupation:_____ Work Title:_____Employer:_____ Lives in the home? Yes No If not biological mother: Age:____Education:_____Occupation:_____ Work Title:_____Employer:_____	
Male Name: _____ Relationship: □ Biological Father □ Step-Father □ Adoptive Father □ Grandfather □ Other Relative □ Unrelated	Age:____Education:_____Occupation:_____ Work Title:_____Employer:_____ Lives in the home? Yes No If not biological father: Age:____Education:_____Occupation:_____ Work Title:_____Employer:_____	
The Child is:	□ Natural □ Adopted □ Other	
The Child's parents are:	□ Married □ Divorced □ Separated	□ Never Married

Please list all siblings, including full, half and step-siblings.	Name:_____ Age:_____ Living with child? Yes No Name:_____ Age:_____ Living with child? Yes No Name:_____ Age:_____ Living with child? Yes No Name:_____ Age:_____ Living with child? Yes No Name:_____ Age:_____ Living with child? Yes No
Please list anyone else living in the home and relationship to the child.	Name:_____ Relationship: _____ Name:_____ Relationship: _____ Name:_____ Relationship: _____
Are there any significant stressors or pressures on the family? Explain if yes.	_____ _____ _____
Primary Language spoken by student:	_____
Other languages spoken in the home:	_____ _____
Medical History	
Date of last physical exam:	◻ Less than 6 months ago ◻ 6-12 months ago ◻ 1-2 years ago ◻ More than 2 years ago
Any Problems with vision or hearing? Explain if yes.	◻ No ◻ Yes _____
Has the child ever had problems with recurrent ear infections? Has the child had surgery to place tubes in ears? Give details if possible	◻ No ◻ Yes ◻ No ◻ Yes _____ _____
Describe any head injuries (e.g., date, what happened, changes in behavior after the injury)	_____ _____ _____
List any hospitalizations or surgeries.	◻ None List hospitalizations: _____ _____
Current medications, dosage, and reason:	Medication: _____ Dosage: _____ How often:_____ Reason: _____ Medication: _____ Dosage: _____ How often:_____ Reason: _____

	Medication: _____ Dosage: _____ How often: _____ Reason: _____ Medication: _____ Dosage: _____ How often: _____ Reason: _____	
Is your child currently experiencing:	☐ Inappropriate/deficient social skills ☐ Abdominal pains/vomiting ☐ Headaches ☐ Sleep difficulties ☐ Eating difficulties ☐ Aggression ☐ Noncompliance at home ☐ Depressed or sullen mood	☐ Impulsive of hyperactivity ☐ Temper tantrums ☐ Anxiety/worry ☐ Clumsiness ☐ Self-injurious behavior ☐ Forgetfulness ☐ Noncompliance at school ☐ Suicidal Thought
Check the following behaviors that describe the child	☐ Self-conscious ☐ Feels inferior ☐ Short attention span ☐ Fails to finish task ☐ Argues, quarrels ☐ Unusual fears ☐ Daydreams ☐ Lacks self-confidence ☐ Brags, boasts ☐ Distractible	☐ Restless ☐ Impulsive ☐ Concerned with bodily changes ☐ Overexcited easily ☐ Sulks and pouts ☐ Rapid mood swings ☐ Overactive ☐ Listless ☐ Changeable ☐ Being Bullied
Check factors affecting family:	☐ Blended family problems ☐ Unemployed ☐ Divorced/separation ☐ Frequent moves ☐ Incarcerations	☐ Parent-child conflict ☐ Sibling conflict ☐ Custody problems ☐ Parent conflict
Describe significant events of concerns affecting your child:	_____ _____ _____	
Has your child ever had contact with a psychiatrist, psychologist, clinic, or private agency? Explain if yes.	☐ No ☐ Yes _____ _____ _____	

Has your child ever had an outside evaluation?	☐ Yes ☐ No Does the school have a copy of the evaluation: ☐ Yes ☐ No
Describe the child's attitude toward school.	
Describe the child's choice of friends (how many, what age, do they get along well).	
What are your child's activities when not in school?	
List your child's chores and responsibilities at home.	
What are your goals for your child's future?	
Consulting Professionals & Other Professionals	
Please list all others involved in the child's care, including physicians, psychologists, social workers , therapist, DCS case workers or probation officers:	Name/profession: Nature of involvement:
Childs Strengths/Weakness	
Please use this space to note the child's strengths:	
Please use this space to note the child's weaknesses:	
Why are you seeking a CST evaluation at this time?	