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| **INTAKE SHORT FORM** |

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| CHILD’S INFORMATION | | | | | | | |
| FULL NAME | | | | GENDER 🞎 Male 🞎 Female | | | DOB |
| CURRENT AGE | | NAME OF SCHOOL | | | | | GRADE |
| PARENT NAME | | | | | PARENT PHONE | | |
| PARENT EMAIL | | | | | DATE: | | |
| PARENT CONCERNS Communication  Academics  Peer Relations  Behavior/Sensory Regulation  Placement/School Day Experiences |  | | | | | | |
| CHILD CONCERNS |  | | | | | | |
| TEACHER CONCERNS |  | | | | | | |
| CONCERNS OF OTHERS | Please specify. (Physician, family members, etc.) | | | | | | |
| OTHER SERVICES AND EVALUATIONS 🞎 None | TYPE OF SERVICE | | DATES/AGE | | | NAME OF PROVIDER | |
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| REFERRAL SOURCE |  | | | | | | |
| To be completed by clinician:PLAN FOR FOLLOW UP |  | | | | | | |

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CLIENT NAME PARENT NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT SIGNATURE DATE

Thank you for taking the time to complete this information about your child.

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PARENT/GUARDIAN SIGNATURE DATE