



Parent Intake Form

Child's Name: _____
Address: _____
City: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____
Birthdate: _____ Age: _____
Parent's Name: _____
Child's Birth: Full Term _____ Premature _____ C-Section _____

Major Developmental Milestones:

Were they met age appropriately? Yes _____ No _____

If not, which ones and describe: _____

Medical History:

Pediatrician: _____

Presently under a doctor's care? Yes _____ No _____

Any medical diagnosis? _____

Medications? _____

Surgeries? _____

Allergies? _____

Education:

School: _____

Current or Upcoming Grade: _____

Hand Dominance: Right _____ Left _____ Mixed _____ At what age? _____

Repeated any grades? _____

Results of educational testing done at school or privately: _____

Does your child attend any special education or tutoring? _____

Has your child ever received Occupational Therapy/related services? _____

Does your child wear glasses? _____

Does your child prefer printing or cursive? _____

What are your concerns about your child's handwriting?

What would you consider a successful outcome to this class?

Anything you would like us to know regarding program planning for your child (e.g., likes, dislikes, behavioral characteristics, food reactions)?

How did you hear about this class?



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