Growing Together Behavioral Center
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Parent Intake Survey For The 2020 – 2021 School Year

Name of Child _____
(First) (Middle) (Last)

Medical Information

Primary Diagnosis: _____ Secondary Diagnosis: _____

Additional Diagnosis: _____

Age of primary diagnosis: _____ Diagnosis by whom: _____

Current medications:

_____

_____

_____

Will any of these medications need to be given at school:

_____

_____

_____

Note: State law requires a doctor's prescription & proper medical bottles to be provided to school before we can dispense medications.

Current nutritional supplements and/or biologics:

_____

_____

_____

Allergies (food, tree, pollen, etc):

_____

_____

Your child and food

Dietary information (restrictions, special diet, etc):

_____

_____

_____

Does your child have any food related aversions/challenging behaviors:

_____

_____

_____

Favorite foods:

_____

_____

_____

Least favorite foods:

_____

_____

_____

Your child and communication

What is your child's primary form of communication (ex. speech, sign, pecs, gestures):

_____

_____

_____

How does your child express his/her needs and wants:

_____

_____

_____

_____

How does your child express frustration/lack of being understood:

_____

_____

_____

_____

How does your child react when told “no” or is unable something desired:

_____

_____

_____

_____

Tell us your child’s best communication skills:

_____

_____

_____

_____

What is most challenging about communication:

_____

_____

_____

_____

Your child and toileting

Is your child toilet trained: Yes _____ No _____

Age when toilet trained: _____

Is your child schedule trained (if yes, please explain): Yes _____ No_____

Additional information:

_____

_____

Has toilet training been tried in the past: Yes_____ No_____

For the question above, if “yes” please explain the procedure used:

_____

_____

What were the successes and challenges in toilet training:

_____

_____

_____

_____

Does your child have any challenging toileting behaviors:

_____

_____

_____

_____

Your child and social/everyday skills

Does your child enjoy playing with others his/her age:

_____

_____

Describe your child's behavior in public places (ex. restaurants, grocery stores, etc):

_____

_____

_____

How well does your child wait (ex. waiting in a line, waiting for food, waiting to go outside to play):

_____

_____

_____

Describe your primary form of discipline (ex. time out, removal of preferred item, etc):

_____

_____

_____

Your Child and Sleep

Does your child sleep through the night: Yes_____ No_____

If no, please describe your child's sleep patterns:

_____

_____

_____

_____

Your Goals

Tell us your goals for your child over the next 6 months:

_____

_____

_____

Tell us your goals for your child over the next year:

_____

_____

_____

Tell us your goals for your child over the next 2 – 3 years:

_____

_____

_____

Previous Therapies

Please tell us about previous therapies your child has received (ex. physical, speech, occupational &/or ABA):

_____

_____

_____

_____

What was most beneficial from these therapies:

_____

_____

_____

_____

What were the biggest challenges with these therapies:

_____

_____

_____

_____

Additional Information

What additional information would you like us to know about your child:

_____

_____

_____

_____

_____

_____