Positive Solutions Psychological Intake Questionnaire

PS&C

740-237-3041

Date:_____

Referrer

Name/Title:_____

Phone Number:_____

Email:_____

Preferred Contact Method: ☐ Phone ☐ Email

Are you (or your school district) new to Positive Solutions and Consultation Services?

☐ Yes ☐ No

If you are new, a contract, payment method or Purchase Order must be established before services can begin.

☐ I am new ☐ I am an existing customer with payment method in place

Are these services for a: ☐ Student ☐ Adult *(check one)*

If a Minor, do you have parent or guardian's consent to contact PS&C? ☐ Yes ☐ No

Client Information

Individual's Name: _____

Individual's DOB: _____

Adult Contact Information

Parent / Guardian Name: _____

Parent or Caregiver's Address (if applicable)

_____

_____

Parent or caregiver's phone number and email address (if applicable)

_____

_____

_____

Are there rights restrictions in place? Describe:

_____

Student Contact Information

What is the student's grade level: _____

Primary Teacher, Intervention Specialist Contact, or other service provider's contact's name, and title: _____

Teacher, Intervention Specialist, or other school contact with whom we can schedule observations and discuss concerns._____

Primary Teacher's Email Address _____

If there is a specific Room number or Home Room Number, indicate here:_____

Name of School and Address (where services are provided) If at home, please write "home"

_____

_____

Location's phone number _____

Individual's Needs Narrative

What are some of the individual's interests? (e.g. hobbies, academics, etc.)

_____

_____

_____

_____

What are some of the individual's strengths? (e.g. Social, academic, talents)

_____

_____

_____

What are the behaviors of concern? _____

_____

_____

When and where are the behaviors most likely to occur? (e.g. specific classroom, time of day, school period etc.) _____

_____

When are they least likely to occur? _____

_____

If the individual has a diagnosis or diagnoses, please list._____

_____

Does the individual take medication? if so...what, when, and how much, for what?

_____

What is the individual's current schedule throughout the day?

_____

_____

Additional Comments (Optional)

_____

_____

If you are in Scioto County Is this referral to be billed through the SCOESC? ☐ Yes ☐ No

Does the student have: ☐ ETR ☐ IEP ☐ BIP ☐ ISP? (*Check those that apply)*

Email copies of each to tanya@positivesolutionsconsult.com

Please forward this student's ETR, IEP, BIP, or ISP (if available) Feel free to attach other supporting documentation.

Which of following best describes you:

- ☐ School District Administrator (e.g. Special education coordinator, student services coordinator, principal)
- ☐ County Board of DD Case Manager or SSA
- ☐ Educational Service Center Administrator

Does the Student have an ETR and/or IEP ? *(Check all that apply)*

- ☐ Student has an ETR, but will send later
- ☐ Student has an ETR that can be emailed
- ☐ Student does not have an ETR
- ☐ Student has an IEP, but will send later
- ☐ Student has and IEP that can be emailed
- ☐ Student does not have an IEP