



Julie Christian
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General Information

Childs Name:	
Date of Birth:	☐ Male ☐ Female
Address:	
City:	State: Zip Code:
School	Grade:
City:	State:
Mother's name:	
Relationship to Child: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Other	
Address:	
City:	State: Zip Code:
Phone	Email:
Father's name:	
Relationship to Child: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Other	
Address:	
City:	State: Zip Code:
Phone	Email:

Siblings' Names and Ages

Intake Information

- Please explain the reason for your referral. Describe in your own words your child's problem as you understand it. Please include difficulties reported by teachers and your observations at home.
- What do you consider to be your child's strengths and weaknesses?
- What would your child's teachers describe as your child's strengths and weaknesses?
- Has your child had previous testing, tutoring or therapies? Please describe.
(Reports are often helpful, please bring them with you to the evaluation.)
- Have other relatives in your immediate or extended families struggled in school or been diagnosed with learning disabilities or ADHD?
- Is English your child's native language? ☐ Yes ☐ No

Developmental/Medical Conditions (Please check all that apply.)

- | | | |
|--|---|---|
| ☐ Complicated Pregnancy | ☐ Vision Impairment | ☐ ADHD |
| ☐ Premature Birth | ☐ Hearing Impairment | ☐ Autism Spectrum Disorder |
| ☐ Illness at Birth | ☐ Developmental Delays | ☐ Anxiety |
| ☐ Serious Accident | ☐ Physical Disability | ☐ Depression |
| ☐ Allergies | ☐ Speech Delays | ☐ Emotional Behavioral Disorder |
| ☐ Learning Disabilities | ☐ Motor Delays | ☐ Oppositional Defiance Disorder |
| ☐ Other (please describe below) | ☐ Dyslexia | ☐ Obsessive Compulsive Disorder |

- Please include additional information including who and when any of the above diagnoses were made.
- Has your child's vision and hearing been checked? Please note dates and results

- Does your child currently take any medications? Please list.

- Did your child receive any early childhood services through the school district?
 - ☐ Birth to Three ☐ Preschool

- Is your child currently receiving therapies or tutoring?
 - ☐ Speech Therapy ☐ Occupational Therapy ☐ Preschool
 - ☐ Other

- Does your child currently receive any services or accommodations at school?
 - ☐ Individualized Education Program (IEP) ☐ 504 Plan
 - ☐ Other

Please check all that apply.

- ☐ Is creative (loves drawing, signing, acting, inventing)
- ☐ Likes to talk and tell stories
- ☐ Is good with fixing or creating with hands, using tools
- ☐ Like to figure out how things work, taking things apart and putting them back together
- ☐ Has a sense of curiosity
- ☐ Enjoys many activities that do not require reading
- ☐ Likes listening to books
- ☐ Difficulty learning how to rhyme words
- ☐ Difficulty learning the letters of the alphabet
- ☐ Difficulty remembering letter sounds
- ☐ Actively avoids tasks that require reading
- ☐ Complains about having to read
- ☐ Shows anxiety or frustration about having to read
- ☐ Dislikes or refuses to read aloud
- ☐ Blinks, rubs or covers eyes frequently
- ☐ Seems to fatigue easily when reading or complains of headaches
- ☐ Confuses little words that look alike (ie. was, saw)
- ☐ Omits words when reading or writing
- ☐ Mispronounces words
- ☐ Does not read as well as peers
- ☐ Reads slowly, may often have to reread to comprehend
- ☐ Takes longer than expected to complete assignments
- ☐ Doesn't comprehend well
- ☐ Poor speller
- ☐ Will spell the same word multiple ways
- ☐ Knows how to spell a word but then forgets, spelling is inconsistent
- ☐ Has poor handwriting (messy or illegible)
- ☐ Difficulty following directions with multiple steps
- ☐ Difficulty sequencing information

- Additional comments and concerns:

Please Read and Sign Below

Questions? Please contact Julie Christian at (605) 321-8374 or keystolearning@icloud.com

By signing below, I consent to services provided by Julie Christian, Keys to Learning, LLC

Parent Signature

Date