Aurora Tutoring School and Resource Center

CLIENT INTAKE FORM FOR CHILDREN & OLDER STUDENTS

(PLEASE PRINT:) Today's date:	Person Completing Form:

CLIENT INFORMATION

Client's Last name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Street Address	City	State and Zip Code	Client's Birth date	Age	Gender	
			/ /		❑ M	❑ F

Client's School	School District in which Client Resides	Highest Grade Completed	Current Grade	Grades Retained

CLIENT'S MOTHER'S INFORMATION

Mother's Name	Mother's Address if Different from Client's	Mother's Home Phone	Mother's Business Phone
Mother's Cell Phone	Mother's Email Address	Mother's Date of Birth	Mother's Marital Status
			Single / Mar / Div / Sep / Wid
Mother's Education	Mother's Employer	Mother's Work Hours	Mother's Position

CLIENT'S FATHER'S INFORMATION

Father's Name	Father's Address if Different from Client's	Father's Home Phone	Father's Business Phone
Father's Cell Phone	Father's Email Address	Father's Date of Birth	Father's Marital Status
			Single / Mar / Div / Sep / Wid
Father's Education	Father's Employer	Father's Work Hours	Father's Position

OTHERS LIVING IN THE HOME

Name	Relationship to Client	Age	Grade

Referred by:

Other family members seen here:

CLIENT MEDICAL HISTORY

(Please Print)

Client Name:	Person Completing Form:

Were there any problems during the pregnancy, labor or delivery for this person?	YES	NO	If YES, please describe below:

Did this person achieve developmental milestones within normal time frames?	YES	NO	If NO, please explain below:

Adverse reactions to vaccines?	YES	NO	If YES, please describe below:

Any bouts of strep infection	YES	NO	If YES, any tics or OCD behaviors following strep? Please explain below:

Any ear infections?	YES	NO	If YES, please answer the following questions:
Broad spectrum antibiotics used:			
Myringotomy (tubes)? If yes, dates:			
Hearing loss? Explain:			

Prior diagnosis of seizures/epilepsy	YES	NO	If YES, in connection with high fever?	YES	NO	Treatment history epilepsy:

Any Allergies?	YES	NO	If yes, allergic to what?

Prior diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or ADD?	YES	NO	If YES, describe treatment:

Current medications & dosages:

CLIENT EDUCATIONAL HISTORY

(Please Print)

Client Name:	Person Completing Form:

Did this person have any developmental delays requiring **early intervention**?	YES	NO	If YES, please describe below:

Did this person require any of the following related services?			What services were provided and when?
Speech and/or Language Therapy	Yes	NO	
Occupational Therapy	Yes	NO	
Physical Therapy	Yes	NO	
Social Skills Training	Yes	NO	

List all Schools Attended	From	To	Grades	List any special education or remedial services provided

Is English this person's *second* language?	YES	NO	If YES, what is this person's first language?	

What language is spoken in the home?____

Was this student every retained? If yes, explain.____

List all **Private Services** Provided (for example, private tutoring, private OT or PT, private Speech/Language, test preparation courses, etc)

Service Provided	From	To	Grades	

Favorite Subjects in School?			
Worst Subjects in School?			
Corrective lenses for vision?	YES	NO	Vision Therapy? If YES, please explain:
Hearing Aides or FM system?	YES	NO	

STUDENT CLASS SCHEDULE

(Please Print)

Client Name:				Person Completing Form:
List Current Classes	Day of Class	What hour of the day?	Current Grade in Class	List the name and email of the teacher for each class