Heal Together Counseling, LLC
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Educational Advocacy Intake Form

Child Name: ______________________________ Nickname: ______________________

Date of Birth: ____________________ Age: ___________ Gender: ______________

Address: ____

City: __________________________ State: ___________ Zip Code: ______________

Phone Number: ___________________________ Lives With: __________________

Parent/Guardian 1:

Name: ____

Date of Birth: ____________________ Age: ___________ Gender: ______________

Address: ____

City: __________________________ State: ___________ Zip Code: ______________

Phone: _____________________________ Email: ____________________________

Do you have legal decision-making authority: Yes No Other: _______________

Parent/Guardian 2:

Name: ____

Date of Birth: ____________________ Age: ___________ Gender: ______________

Address: ____

City: __________________________ State: ___________ Zip Code: ______________

Phone: _____________________________ Email: ____________________________

Do you have legal decision-making authority: Yes No Other: _______________

Parent Relationship Status:

Single   Married   Partnered   Divorced   Separated   Widow(er)

Emergency Contact (different from parent):

Name: ______________________________ Relationship to client: ____________

Address: ____

City: ______________________ State: _______ Phone: ____________________

Email: ____

Dept. of Children, Youth & Families:

Involvement in DCYF: None   Prior   Current

If yes, reason for involvement: ____

Legal authority to sign for client: _____________________________________

CPSW: ______________________________ Phone: _______________________

Military Service:

Has anyone in your family served in the military?   Yes   No

Who: ____

Branch: Army   Navy   Air Force   Marines   Coast Guard   National Guard

Status: Active Duty   Reserves   Inactive Ready Reserves   Veteran

Has anyone in your family experienced a deployment?

Who: ___________________________ When: ______________________

Challenges: ____

Medical Information:

Diagnosis (medical & mental health):

Diagnosis:	Date Diagnosed:	Diagnosed By:

Current Medications (list all):

Current Medication	Reason

Prior Testing (check all that apply & complete):

Prior Testing	Agency	Testing Date	Result
• No Testing			
• Neuro-psych			
• Educational			

School Information:

School Name: ____ Grade: ____________

Special Education: None IEP 504

Current Services (check all that apply & complete):

Service	Frequency per Week	Location
• OT		School Clinic
• PT		School Clinic
• Speech		School Clinic
• ABA Therapy		School Clinic
• Vision Therapy		School Clinic
• Hearing Therapy		School Clinic
• Mental Health:		School Clinic
• Other:		School Clinic

Concerns:

What are your current concerns:

____

____

____

____

____

How long have these issues been a concern: ______________________________

Has the school attempted to address these concerns: Yes No Somewhat

What support would you like to receive from an Educational Advocate:

____

____

____

____

Referred By:

Name/Facility: ____

Address: ____

May I Thank Them? Yes No