



**CASA COLINA CHILDREN'S SERVICES CENTER
Parent Intake Questionnaire**

PLEASE PRINT CLEARLY

CHILD AND FAMILY PROFILE:

Child's Name: _____ Date of Birth: _____ Today's Date: _____
 Person completing questionnaire: _____ Relationship to child: _____
 Parent's/Guardian's Name: _____
 Home Telephone Number: _____ Cellular Phone Number: _____
 Email Address: _____
 Address: _____

Are parents: Married Not Married Separated Divorced
 Other people living in the household: _____
 Does the child have any siblings? (If yes how many do they have and what are their ages?) _____

 Primary Language spoken at home: _____
 Additional languages spoken at home: _____

SERVICES:

Program	Currently receives and how much? (ex. 1 time a week)	Received in the past and how much? (ex. 1 time a week)	Name of facility	Specialist's Name and Phone Number
Pediatrician				
Neurologist				
Early Intervention				
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Day Care				
Other:				

Who referred your child for this evaluation? _____
 Reason for seeking therapy: _____

Medical/Health History:

Current diagnoses: _____
 Date diagnosed: _____ Age at diagnosis: _____
 Who diagnosed the child: _____

Complications during pregnancy? Yes No. If yes, please describe. _____

 Born Full-Term: Yes No. If no, at how many weeks? _____ Birth Weight? _____

Complications after birth? Yes No. If yes, please describe. _____

Feeding difficulties as a newborn or infant? Yes No. If yes, please describe.

Has your child ever been hospitalized and if so, when/why? _____

Does your child have chronic ear infections or have tubes in the ears? _____

Date of last hearing test? _____ What were the results? _____

Date of last vision test? _____ What were the results? _____

Any medical tests (blood, allergy, MRI, EEG, etc.) or developmental tests (i.e., psychologist)?

Yes. No. If yes, when and what were the results? _____

Current medications (and describe purpose and frequency) _____

Please list any allergies: _____

Does your child have any special dietary restrictions: _____

Does your child sleep through the night? Yes No.

Does your child have a current immunization record?

Yes (Please provide front office with a copy) No (Please see front office staff for opt out form)

Developmental Milestones

Indicate at what age your child acquired the following skills. If your child cannot do the skill, write NA.

_____ Rolled over _____ Independent sitting _____ Independent standing
 _____ Walked _____ Spoke first words

Educational History

Does, or has, your child attend(ed) preschool? Yes No

If so, where: _____ School District: _____ How long? _____

Indicate the name of the elementary, middle or high school, and school district, that your child is currently attending. _____

Teacher's Name: _____ Current Grade Placement: _____

Has the teacher expressed any specific difficulties your child may have in and/or outside of the classroom? Yes No If so, please list: _____

Has your child received any testing or special services through the public school system?

Yes No If so, please explain: _____

Does your child currently receive learning assistance through school? Yes No If so, how often: _____

Does your child have a current Individualized Education Plan (IEP)? Yes No

What are your concerns about your child's participation in daily activities?

LEARNING STYLE

What do you feel is a barrier to your child's education/learning? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Language | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> Communicative |
| <input type="checkbox"/> Attention/Learning | <input type="checkbox"/> Motivational |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Pain |

Is your child motivated to attempt dressing tasks (for example, attempts to remove socks but is unsuccessful)? _____

Is your child toilet trained? _____

Able to clean self? _____

	Always Independent	Needs Help	Completely Dependent/ Does Not Do
<u>Feeding Development</u>			
Eats solid foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eats a variety of foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sits at table	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeds self with fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeds self with spoon/fork (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinks from a regular cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sucks from a straw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cuts foods with a knife and fork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get self a drink of water from the tap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets self a simple snack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepares a simple meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any concerns about your child's eating patterns (for example, very picky eater)?

Yes No If yes, please describe

Does your child need reminding to use a spoon instead of eating with his/her hands?

Yes No

Community Involvement

Is your child involved in any community activities, such as sports teams, Boy Scouts, etc? Please list: _____

Does your child like to go out into the community (for example, the park, store, restaurant)?

Yes No Please describe: _____

Is your child safe when in the community (holds your hand, stays close to you)? _____

Play/Social Development

What are your child's favorite toys, activities, TV shows/videos/music? _____

Does your child play with the toys appropriately? _____

What play activities is your child able to do independently at home? _____

Does your child play these favorite toys/activities with other children, parents, or alone?

other children parents alone

Does your child have good eye contact with adults and with other children?

How does your child relate to his/her siblings (do they play together/what do they play)?

Does your child show interest in other children? Yes No If yes, how does he/she show that interest? _____

How does your child do with other people visiting your home? _____

Does your child ride a two wheeled bike? Yes No Describe: _____

Is your child able to swim independently? Yes No Describe: _____

Emotional/Behavioral Development

Check any of the following which have been and/or currently are a problem with your child.

	Daily Problem	Weekly Problem	Past Problem	Not a Problem
Difficult to discipline				
Easily upset				
Temper tantrums				
Poor eye contact				
Prefers to be alone				
Poor sleeping patterns				
Destructive with objects/property				
Self-injurious				
Aggressive with others				
Unusually active				
Unusually inactive				
Difficulty with siblings				
Difficulty with other children				
Difficulty receiving/giving affection				
Easily frustrated				

Language Development

Do you have any concerns about you child's speech/language? Yes No If yes, please describe. _____

For what reasons does your child communicate?

- To express needs
 To express emotions
 To request activities/objects
 To interact with others
 To share information

Does your child understand verbal instructions? Most of the time Some Very little
 Please give examples of directions/comments your child follows/understands at home (e.g., time for a bath, get your shoes, give me the ball). _____

Do you use gestures/actions to help your child understand verbal directions? Yes No

Did your child ever begin to use words and then stop babbling/speaking? Yes No
 If yes, At what age did your child begin speaking? _____ At what age stopped? _____

Are other languages than English spoken at home? _____

Does your child speak clearly (articulation)? Yes No

How does your child express frustration? _____

<i>Does your child...</i>	Frequently	Sometimes	Rarely	Never	Age first occurred
Use single words?					
Combine words (e.g., more juice)?					
Speak in sentences?					
Use familiar sayings/phrases?					
Repeat words?					
Try to repeat sounds/words when asked?					
Copy gestures (clapping, finger plays)?					
Use sign language?					

PERFORMANCE SKILLS:

Does your child follow the daily routine and/or transitions:
 With ease, consistently Requires assistance Tantrums/resists transitions
 How does your child respond to challenging/non-routine events? _____

Frustration Tolerance: Average Poor
 Activity level for daily activities: Appropriate High Low
 Does your child rush through work/effortful activities? Yes No

SOCIAL/PLAY SKILLS:

Initiates interaction with others: Yes No If yes, does your child have friends outside of the family? _____
 Responds to other's interactions: Yes No
 Follows social conventions (appropriate for social group expectations): Yes No
 Complies with adult directions/rules: Always Sometimes Never
 What areas of their social/play skills need improvement? _____

ATTENTION TO ACTIVITIES:

- focuses on task until completion without individual assistance
- requires repeated redirection
- other: _____

ORGANIZING SPACE AND OBJECTS:

- Is your child able to find routinely-used objects in room, class, desk, or backpack quickly when needed? Yes No
- Does your child return routinely-used materials and objects to their storage location? Yes No
- Is your child able to maintain participation in a large room/open space? Yes No
- Does your child initiate activities? Yes No
- Is your child able to engage in a multi-step activity (i.e. craft)? Yes No
- Is your child able to sequence/time task? Yes No
- Does your child engage in new/unfamiliar activities? Yes No
- Is your child able to get on/off, in/out playground equipment, etc? Yes No
- Does your child follow actions in songs or class (i.e. holiday/event) presentations? Yes No

VISUAL PERCEPTUAL:

- Does your child have difficulty telling the difference between similar symbols such as b and p, + and x? Yes No
- Does your child have difficulty finding an object in a group of other objects, such as in a cluttered drawer, or among other toys? Yes No
- Does your child have difficulty discriminating between changes in surface levels, such as stepping off a curb or mat? Yes No
- Does your child have difficulty controlling eye movements, such as following a ball with his/her eyes? Yes No

OTHER:

Please provide below or on a separate sheet of paper, any other information you wish for us to know, or feel would be beneficial, in our comprehensive assessment of your child. Also include copies of any recent report cards, evaluation reports or academic paperwork.

All information is held in the strictest of confidence.

Thank you for providing us with the opportunity to assist your child and family.

Please return this form to:

Casa Colina

Children's Services Center; Building #10

255 E. Bonita Ave.

Pomona, CA 91769-6001

Fax #: 909-596-3548

Phone #: 909-596-7733 Ext. 4200