*49 Walpole St., Suite 5, Norwood, MA 02062 * (o) 781-762-3750 * (f) 781-762-3770 * www.learningsolutionsforme.com *

CLIENT/FAMILY INFORMATION AND HISTORY FORM

Child's Name: _____ D.O.B._____ M____ F_____

Person Completing this form: _____ Relationship to Child: _____

Nickname or name child routinely goes by: _____

Current Address of Child: _____

Current Phone Contact for Parent/Guardian of Child: _____

Current Email Contact for Parent/Guardian of Child: _____

Emergency Contact (Not Parent/Guardian) for Child: _____

Primary Language of Child/Home: _____ Secondary Lang.: _____

**LS is unable to provide translators for either Child or Parent/Guardian at this time.*

Primary Physician: _____ Phone: _____
Fax: _____

Referring Physician: _____ Phone: _____
Fax: _____

Current Psych pharmacologist:_____ Phone: _____
Fax: _____

Current Therapist/Counselor_____ Phone: _____
Fax: _____

FAMILY INFORMATION

Mother's Name: _____ DOB:_____ Occupation: _____

Father's Name: _____DOB: _____ Occupation: _____

Parents are: Married _____ Divorced _____ Separated _____ Widowed _____ Single _____

- If divorced, who has physical custody? _____ Is it full or joint?_____
- Who has legal custody? _____ Is it full or joint? _____

**Please inform LS of any applicable custody restrictions or orders that impact pick-up/drop-off/consent.*

Is this Child: Your Biological Child _____ Step Child _____ Adopted Child _____ Foster Child _____

Persons living in the home: _____

_____

*49 Walpole St., Suite 5, Norwood, MA 02062 * (o) 781-762-3750 * (f) 781-762-3770 * www.learningsolutionsforme.com *

MEDICAL HISTORY

Is your child currently in good health? _____ YES _____ NO **If No, please explain*_____

_____

Do you have concerns regarding your child's hearing/vision? _____

Diagnosis	ICD-9 or DSM codes	Diagnosing Doctor	Date Diagnosed

Client/Family Mental Health History: (check all that apply/list relation to client)

	Relation		Relation		Relation
__Autism	_____	___Bipolar	_____	___Depression	_____
__ADHD/ADD	_____	___Anxiety	_____	___Irritability	_____
__Impulsivity	_____	___Panic Attacks	_____	___Fatigue	_____
__Hearing Loss	_____	___Learning Disabilities	_____	___Language Delays	_____
__Sensory Defensive	_____	___Sleep Disorder	_____	___Appetite Issues	_____
__Obsessive Thoughts	_____	___Frequent Illness	_____	___Frequent Pain	_____
__Dyslexia	_____	___Lethargic	_____	___Withdrawn	_____
__Abuse/Neglect	_____	___Excessive Talking	_____	___Stroke:	_____
__Other:	_____	_____			

Current Diagnose(s) of Child: _____

_____

Is your child taking any medications? (Please list):

Medication	Dosage and Frequency	Purpose	Prescribing Doctor

Please list any **allergies** your child has: _____

Does your child have an Epi-Pen/Allergy Plan: _____

Does your child have any **dietary restrictions**:_____

Other medical conditions/information: _____

_____

*49 Walpole St., Suite 5, Norwood, MA 02062 * (o) 781-762-3750 * (f) 781-762-3770 * www.learningsolutionsforme.com *

EDUCATIONAL HISTORY

School Name: _____ District: _____ Grade: _____

Is your child in school for a full day? _____If not – how many hours? _____

Current Teacher(s): _____

Does your child's teacher have concerns about him/her: _____

_____

Please list special education services your child receives (IEP/504/behavior plan): _____

_____

Has your child ever received Applied Behavior Analysis (ABA)? If yes, how long, and when was the last date of services _____

Does your child receive SLP/OT/PT services at school and outside of the school?

Service Type	Provider	How many hours AT school?	Hours OUTSIDE of school?	Total hours/Wk
ABA				
SLP				
OT				
PT				
Counseling/Therapy				
Ex. Function				
Social Skills				
Daily Living Skills				
Parent Training				

Communication Skills: Primary method of communication: ☐ Picture Communication ☐Sign Language ☐ACC ☐ Verbal ☐Gestures

Comments: _____

_____

Barriers to Communication: ☐Impaired Articulation ☐Echoic ☐Prompt Dependent ☐Weak Speaker Skills ☐Weak Listener Skills ☐Weak Interpretation of Non-Verbal Communication ☐ Weak Conversation Skills ☐ Hearing Deficit☐ Attention Deficit

Comments: _____

_____

*49 Walpole St., Suite 5, Norwood, MA 02062 * (o) 781-762-3750 * (f) 781-762-3770 * www.learningsolutionsforme.com *

Social and play:
Does your child seek out interaction with ☐Parents ☐ Siblings ☐ Other adults ☐ Peers
Does your child play ☐ independently ☐ Next to other children ☐ only by him/herself?
What play skills does your child have? ☐ Plays with toys appropriately ☐ play easy card games appropriately ☐ play board games ☐ Takes turns ☐ following the rules of the game ☐ Keeps score ☐Follows rules of a game ☐ Follows changing rules of a game ☐ Other: _____

Comments: _____

_____

Has your child experienced: ☐ Isolation from peers ☐ Problem making friends☐ Problem keeping friends ☐ Problem controlling temper ☐ Being teased/bullied ☐ Teasing/bullying others ☐ Lack of motivation ☐ Behavior concerns at school ☐ Safety Concern(S): *Please Explain_____ ☐ Other: _____

Comments: _____

_____

Behavior: ☐ Physical stereotypical behavior ☐ Verbal stereotypical behavior ☐ Perseverations

Comments: _____

_____

Challenging behavior: ☐ Physical aggression ☐ Self-injurious behavior ☐ Running/Bolting ☐ Verbal aggression ☐ Yelling, screaming ☐ Opposition ☐ Other _____

Triggers (if known): _____

Settings: _____

Frequency: _____Intensity:_____

Function of the behavior ☐ To get attention ☐ to escape, avoid non-preferred tasks, demands ☐to get preferred items, activities ☐ for no obvious reasons

Variables that may contribute to aversive behaviors & impede learning: ☐ Auditory Noise ☐Verbal Deficits ☐Visual Distractions ☐ Environment ☐ Time ☐ Crowds ☐ Proximity to others ☐ Transitions ☐ Failure to Generalize ☐ Negative Behaviors ☐ Lack of Instructional Control ☐ Sensory Defensive ☐ Impaired Social Skills ☐ Impaired Attending ☐ Reinforcement Dependent ☐ Self Stimulation ☐ Obsessive-Compulsive Behaviors ☐ Hyperactive Behaviors ☐ Attention ☐ Lack of Eye Gaze/Contact ☐ Other_____

Adaptive Living Concerns: ☐ Toileting ☐ Eating ☐ Dressing ☐ Independent Play ☐ Social Play ☐ Group Skills ☐ Fine Motor ☐ Gross Motor ☐ Household Routines ☐ Bathing ☐Tooth brushing

*49 Walpole St., Suite 5, Norwood, MA 02062 * (o) 781-762-3750 * (f) 781-762-3770 * www.learningsolutionsforme.com *

☐ Hair ☐ Cleaning ☐ Leisure Time

Executive Function Concerns: ☐ Organization ☐ Emotional Regulation ☐ Planning ☐ Problem Solving ☐ Time Management ☐ Impulse Control ☐ Inhibition Control ☐ Other: _____

Comments: _____

_____

Possible Reinforcers/Motivators:

☐ Hobbies _____

☐ Prefered Interest_____

☐ Talent _____

☐ Reward/Earned Incentive_____

☐ Current Positive Behavior Plan in place _____

_____

Comments: _____

_____

Have you provided the following documents required to help Assess/Supplement/Reinforce a treatment plan for your child; and required for insurance prior authorization if/when applicable?

Document	**Provider**	**Yes**	**No**	**N/A**
*Physician Diagnosis Report(s) with referral for specific services, **dated within last 6 months**				
*Most Recent Evaluation(s) (Neurology/Developmental/Neuropsychology/ SLP/OT etc.)				
Progress Reports/ Written Service Plans				
*Current IEP/ 504 Plan				
*Current Behavior Intervention Plan				
*Other Related Reports				

Thank you for your time and effort completing these questions. We value your answers/information in determining how we can best support and strengthen skills and development of your child.