North Star
EDUCATION SERVICES INTAKE FORM

(Please Print)

Today's date:			Person Completing Form:		
CLIENT INFORMATION					
Client's Last name	First	Middle			
Street Address	City	State and Zip Code	Client's Birth date / /	Age	Gender ☐M ☐F
Client cell phone	Client email address	Highest Grade Completed			
Client Cell phone:					
CLIENT'S MOTHER'S INFORMATION					
	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		
BILLING INFORMATION					
Responsible Party #1		Responsible Party #2			
Name		Name			
Address		Address			
City, State, Zip		City, State, Zip			
Responsible for _____% of Bill		Responsible for ___% of Bill			
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:

Family History of Learning, Social, Emotional Challenges?	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 or current diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or ADD; anxiety, depression or other psychiatric conditions?	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, social skills training, counseling 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:

How may we assist you? (list questions, areas of concern, service needs etc…)

Please send in with this form all pertinent evaluations, IEPs, progress reports, school and medical records