



Early Intervention Program Intake Form

Date: ___/___/___

Child's Name: _____ Date of Birth: _____

Parent/Guardian Names: _____

Address: _____ City _____ State ____ Zip _____

Phone: (____) _____

REFERRAL INFORMATION

Who is making referral? Parent/Guardian School District Pediatrician Regional Center
(Circle one)

Name of Referral Source: _____

Address: _____ City _____ State ____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Email _____

School District _____ Contact Person _____

Position/Title _____ Phone Number (____) _____

Address _____ City _____ State ____ Zip _____

Is the child a client of Regional Center? Yes No (If No - skip this section)

Regional Center Caseworker _____

Address _____ City _____ State ____ Zip _____

Phone Number (____) _____ Email _____

How to contact us:

Online at: www.thebayschool.org

5400 Soquel Avenue, Suite F

Santa Cruz, CA 95062

Tel: 831-462-9620

Fax: 831-462-9616

CHILD'S CURRENT SERVICES

Clinical Services Information

Does your child participate (now or in the past) in any clinical services (*e.g., speech, OT, PT*)? Yes No

If yes, please describe:

Service	Provider	Contact Information	Date Started (& ended)	Hours per week?

Please attach most recent provider reports including goals & objectives statement.

Educational Services Information

Does your child attend school?

If yes, please describe your child's classroom/school setting:

Number of students in room: _____ Staff to student ratio: _____ Special Ed or Regular Ed?
Date enrolled: _____ Days & times of attendance: _____

Please describe other services and/or activities in which your child participates:

Activity	Provider	Contact Information	Date Started (& ended)	Hours per week?

<p>MATERIALS TO INCLUDE WITH THIS FORM</p> <ul style="list-style-type: none"><input type="checkbox"/> Copies of psychological reports with the diagnosis<input type="checkbox"/> Other relevant reports that are available<input type="checkbox"/> Cognitive/IQ tests<input type="checkbox"/> Client Development Evaluation Report (<i>if Regional Center client</i>)<input type="checkbox"/> Current IPP (<i>if Regional Center client</i>)	<p>Please mail your Intake Form to: The Bay School 5400 Soquel Avenue, Suite F Santa Cruz, CA 95062</p>
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These questions are designed for children across a range of ages and abilities. If a question does not apply to your child, please respond with “Not Applicable” (N/A). Your accurate responses are helpful in our initial assessment process. Thank you for your time!

BACKGROUND INFORMATION

Child’s biological parents? _____
 Was child adopted? Yes No

Who lives in the home? If there is a second custodial home, please indicate the occupants of second home.

Name	Age (optional)	Relation to Child

MEDICAL INFORMATION

Were any of the following present with your child? If so, please describe briefly.

Complications with pregnancy?	Yes	No	_____
Complications with birth?	Yes	No	_____
Vaginal birth?	Yes	No	_____
Premature gestational age?	Yes	No	_____

Were you ever concerned about your child’s hearing? Yes No
 If yes, what were your concerns? _____
 Did you have a hearing assessment conducted? Yes No If yes, when? _____

Please indicate if/when your child had any of the following:

Condition/Incident			Date
Allergies	Yes ___	No ___	_____
Seizures	Yes ___	No ___	_____
Bumps to head (requiring medical attention)	Yes ___	No ___	_____
Emergency room visits?	Yes ___	No ___	_____
Hospitalizations	Yes ___	No ___	_____
For what? _____			
Other medical conditions?	Yes ___	No ___	_____
Please indicate condition: _____			

Is your child currently taking any medications? Yes No

If yes, please list below:

Medication Date Prescribed Dosage Administration Times Used for:

Please describe your child's eating habits _____

Please describe your child's sleep habits _____

Family Medical History

Family history of behavioral/psychological problems? Yes No

Concern How is person related to child?

DEVELOPMENTAL INFORMATION

Age child sat independently (and could maintain sitting for a period of time)? _____

Age child crawled? _____

Age child began walking (unassisted)? _____

Age of meaningful first word? _____ (N/A)

What were first words? _____ (N/A)

Age of meaningful two-word phrases _____

(e.g., "Go car," "My cup")

At what age did you first begin to have concerns about your child's development? _____

What were your first concerns? _____

Were the first concerns indicated to you by someone else (e.g., pediatrician, day care provider)?

If so, whom? _____

What were that person's initial concerns? _____

Age of using gestures _____ (N/A)

(e.g., waving, pointing; not reaching for or leading an adult to a desired item)

Has your child exhibited any apparent loss in skills? Yes No

If so, what skills? _____

BEHAVIORS OF CONCERN

Does your child exhibit any of the following behaviors?

Repetitive behaviors	Yes	No	Social withdrawal	Yes	No
Physical aggression	Yes	No	Self-injurious behavior	Yes	No
Property destruction	Yes	No	Self-stimulatory behavior	Yes	No
Ritualistic/obsessive behaviors	Yes	No	Unsafe/dangerous behavior	Yes	No

Please describe any/all of the behaviors marked "yes":

Behavior When did this begin? What (if anything) have you tried to improve it?

Does your child exhibit any other behaviors that you consider problematic? Yes No

If yes, please describe. Please number your concerns in order of priority.

Behavior When did this begin? What (if anything) have you tried to improve it?

LANGUAGE SKILLS

Expressive Language Skills

Describe your child's ability to babble speech sounds _____

Describe your child's spontaneous language _____

Describe how your child indicates what she/he wants _____

Describe the type and number of items that your child asks for _____

Describe your child's ability to imitate vocal sounds, words, phrases _____

Describe your child's ability to label items, events, or actions (*Spontaneous? How many? How often?*) _____

Describe your child's ability to answer questions _____

Receptive Language Skills

Describe your child's ability to follow directions and routines *within context* or with a model _____

Describe your child's ability to follow directions and routines *out of context* or without a model _____

- | | | |
|--|-----|----|
| Can your child follow directions give to a group of children?
How large of a group? _____ | Yes | No |
| Can your child select a named item from a field of two or more items? | Yes | No |
| Can your child point to named body parts? | Yes | No |
| Can your child point to named colors? | Yes | No |
| Can your child point to "big" vs "little"? | Yes | No |

MOTOR SKILLS

Motor Imitation

- | | | |
|---|-----|----|
| Can your child simple motor movements such as clapping or waving? | Yes | No |
| Can your child imitate actions using objects?
(<i>e.g., if someone says "do this" and models use of an object</i>) | Yes | No |
| Can your child imitate finger-play actions with a song? | Yes | No |
| Within a group? | Yes | No |

Gross Motor Skills

Describe your child's gross motor skills, in general _____

Please mark the skills your child is able to do:

Throw a ball _____ Kick a ball _____ Bounce a ball _____ Catch a ball _____

Roll a ball _____ Raise arms up _____ Jump on one foot _____ Twirl arms _____

Fine Motor Skills

Describe your child's fine motor skills, in general _____

Please mark the skills your child is able to do:

Scribble _____ String beads _____ Write letters _____ Write words _____

Draw picture _____ Use scissors _____ Draw lines _____ Draw shapes _____

Itsy Bitsy Spider _____ Write name _____

Self-Help Skills

Describe how your child feeds him/herself _____

Does your child wash/dry hands independently? Yes No _____

Is your child toilet trained? Yes No _____

What program did you use/have you tried, if any? _____

Describe your child's dressing skills _____

Describe any household tasks that your child assists with _____

Describe how your child responds to situations of danger _____

Social Skills

Who does your child make eye contact with (*please circle*)

Mother Father Siblings Familiar People Others

Describe your child's response when addressed by others _____

Describe your child's interest in being with others (*children, adults, familiar/unfamiliar*) _____

Describe your child's interest in doing what others are doing _____

Describe your child's ability to participate in turn-taking activities _____

Play Skills

Describe your child's play with toys (*identify the toys, type of play, and length of time involved*) _____

Does your child ever use toys in an unusual manner (e.g., rubbing items against lips, tasting, spinning) _____

Describe your child's use of toys as intended or self-stimulatory objects _____

Describe your child's interactive play with other children _____

Describe your child's imaginative and pretend play _____

Academic Skills

Please mark the skills your child is able to do:

Recites alphabet _____ Labels letters _____ Can count to what number? _____

Counts with one-to-one correspondence _____ Reads words _____ Stacks blocks _____

Completes puzzles _____ Orders items smallest to biggest _____ Points to named letters _____
What type? _____

Points to named numbers _____ Labels numbers _____ (up to what number? _____)

CHILD PREFERENCES

Identify items that your child enjoys in the following groups:

Food: _____

Toys: _____

Praise, high fives, hugs, etc: _____

Physical activities: _____

Describe any other items and/or activities that your child enjoys. _____

What would your child do if left alone for a period of time? _____

Does your child do tasks for the pleasure of completing the task and being recognized for having finished? _____

EXPECTATIONS/NARRATIVE

Please describe how you believe your child learns best _____

Describe skills that you view as a priority for your child (e.g., language, socialization, problem behaviors) _____

Describe your goals for your child.

Short-term: _____

Long-term: _____

THANK YOU FOR TAKING THE TIME TO ANSWER THESE QUESTIONS!