



## Intake Form

Child's Full Name \_\_\_\_\_

Date of Birth (Year/Month/Day) \_\_\_\_\_

Program applying for, Circle one:

**Specialized Services**

**Behaviour Developmental Services**

### Contact Information

Parent/Caregiver #1: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Parent/Caregiver #2 \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Home Address: \_\_\_\_\_

Siblings (Names and Ages):

\_\_\_\_\_  
\_\_\_\_\_

School and Current Grade:

\_\_\_\_\_

School Hours: \_\_\_\_\_

Program hours preferred (circle one):

AM

PM

AfterSchool

Weekday Availability (circle one):

Monday

Tuesday

Wednesday

Thursday

Friday

Names of family members who may participate in therapy sessions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FSCD Worker: \_\_\_\_\_

Primary Language at home: \_\_\_\_\_



Other language(s) spoken in the home: \_\_\_\_\_

What is your child's diagnoses? When was it given and by whom?

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Has your child been involved with any specialists? If so, who and when?

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Has your child had any previous Speech Language Pathology, Occupational Therapy, Psychology or Physical Therapy services?

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Are there any medical conditions we need to be aware of (i.e. allergies, seizures, etc.)?

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Is your child taking any medications? If so, which kind?

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TOP PRIORITIES:

- 1)
- 2)
- 3)

*Self Care Skills:* Does your child require assistance with self-care skills (i.e. bathing, eating, dressing, toileting, brushing teeth, etc.)? How much assistance is required? Is your child able to do any of it independently?

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*Eating/Meal times:* Does your child have any feeding concerns (i.e., problems with sucking, swallowing, drooling or chewing, etc.)?



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*Sleep:* Do you have any concerns with your child's sleep?

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*Sensory:* Does your child have any sensitivities to noise, touch, lights, sounds? Does your child seek movement or touch?

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*Communication:* How does your child communicate (e.g., gestures single words, short phrases or sentences)? Does your child use an augmentative form of communication (e.g., picture exchange, iPad)?

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*Behaviour:* Are there any current challenging behaviours that you find impact your family functioning on a daily basis (e.g., hitting or biting themselves or others, crying, screaming, difficulty with transitions, defiance, etc.)?

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*Play and Social:* How does your child occupy their free time? Do they have preferred toys or activities? Does your child play with other children? Prefer to be alone?

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What are some of your child's strengths? What motivates your child?

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Is there anything your child dislikes or fears?

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Please comment on any other information you feel may be relevant:

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Parent Signature

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Date

Please Note: The demand for service is extremely high and so we have developed the following process to quickly fill the available spots. When your name comes to the top of the waitlist, the Coordinator will contact you. If we do not hear back, a follow up call and e-mail (if provided) will occur 2 days later. If still no word back we will try again. If not response at that time, a letter will be mailed out and your request for service will be placed at the bottom of the wait list.