

Epstein Education Intake Form**1) Student Information:**

Name: _____ Today's Date: _____

DOB: _____ Gender: _____

Current school and grade: _____

Student personal email address (if applicable): _____

Student cell phone (if applicable): _____

Student sign in information for school portal (Canvas, Schoospeak, Googleclassroom, etc):
_____Student's homeroom/advisory/primary teacher contact information:
_____**2) Parent/Legal Guardian A:**

Name: _____ DOB: _____

Best email: _____ Best phone: _____

Home address: _____

Occupation: _____

3) Parent/Legal Guardian B:

Name: _____ DOB: _____

Best email: _____ Best phone: _____

Home address: _____

Occupation: _____

4) **Parent/Legal Guardian A:** Marital Status: _____

Parent/Legal Guardian B: Marital Status: _____

Is the child adopted? _____ If yes, at what age? _____ If yes, does the child know? _____

Which parent does the child live with? _____

5) Siblings and/or Other Members of the Household (Including Caretakers)

| Name | Relationship to Child | Age |
|------|-----------------------|-----|
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6) Family History

Please indicate if anyone in the family (including parents, siblings, grandparents, etc) has (or had) ADHD, dyslexia, autism, specific learning disorders, mental health disorders (bipolar, OCD, anxiety), substance abuse, and/or other medical related problems.

Please describe any recent changes in circumstances at home (*ie.-new baby, move, family illness/death, divorce, job change, etc*).

7) Medical/Health History

Pediatrician's Name: _____ Date of Last Physical: _____

Describe any childhood illnesses, accidents, surgeries, and hospitalizations. Include date of occurrence and complications.

Describe any current illnesses or medical problems.

Has your child been vaccinated against Covid 19? _____ date(s): _____

Was your child's development delayed or problematic with regard to any of the following developmental milestones (circle to indicate an issue):

Speech Motor Coordination Bed-wetting Feeding/Eating Language

Please explain any of the above:

Allergies: Y/N _____ If Yes, please list: _____

Please list any medications administered to/taken by the child daily, the reason for the medication, and the specialty of the person prescribing the medication. Please include any herbal and natural remedies as well.

| Medication | Reason/Purpose | Specialist |
|------------|----------------|------------|
| | | |
| | | |
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| | | |

Please list all forms of therapy (ie-behavioral, psychological, speech, physical, occupational, etc.) the child has received in the past three years, the reason and the specialist's title.

| Therapy | Reason/Purpose | Specialist | Date/Duration |
|---------|----------------|------------|---------------|
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Chronic ear Infections: Y/N_____Deaf or Hard of Hearing: Y/N____Cochlear Implants: Y/N

Date of Last Hearing Test and Results: _____

Please describe any hearing complications_____

Wears Glasses: Y/N_____Wears Contacts: Y/N____Reason for Glasses/Contacts_____

Date of Last Vision Test and Results: _____

Complains of/or experiences any of the following while reading (*circle*): Headaches____Blurry Vision____Sleepiness____Watery Eyes____Seeing Double____Words on page are fuzzy/blurry/jumping

On average, how many hours per night does your child sleep?_____

At what age did your child start: Crawling____Walking____Talking____Toilet Training_____

Was your child's development delayed or problematic with regard to any of the following developmental milestones (*circle*):

Speech____Motor Coordination____Bed-wetting____Feeding/Eating____Language

Weight____Sitting/walking/running____Interacting with peers____Understanding simple directions____Separating from parents

Please explain any of the above:

Please list any complications during pregnancy:

Length of Pregnancy: _____

7. Educational History

Please list the name of the the school your child attended, the age upon entrance, and circle whether the experience was a positive or negative.

Preschool: _____ Age entered: _____ Postive/Negative
 Elementary School: _____ Age entered: _____ Postive/Negative
 Elementary School: _____ Age entered: _____ Postive/Negative
 Middle School: _____ Age entered: _____ Postive/Negative
 Middle School: _____ Age entered: _____ Postive/Negative
 High School _____ Age entered: _____ Postive/Negative
 Hlgh School _____ Age entered: _____ Postive/Negative

At what age did your child learn to read? _____

Does your child like to read? Please elaborate _____

Does your child like school? Please elaborate _____

What are your child's strongest subjects? _____

What are your child's most challenging subjects?

How would you describe your child's grades? _____

Describe any concerns expressed by teachers: _____

Describe any concerns expressed by the child around school: _____

Does your child have difficulty following directions or paying attention at home? _____

Where and when does your child do homework? _____

How much time does your child spend on homework each night? _____

Does your child need reminders/prompting to do homework? _____

Rate your child's organization with regard to the following on a scale of 1 to 5, 5 being highly organized:

Overall _____ backpack _____ desk _____ room _____ homework _____

Has your child been assessed by a psychologist? Y/N If Y, name and date of assessment

Does your child have an IEP? Y/N If Y, then when was the last one? _____

Describe any special services/accommodations your child receives from school: _____

What are 4 adjectives that describe your child?

What do you admire most about your child?

What are your expectations regarding the work your child will do with me?

Thank you!
Lisa Epstein
Epstein Education

If your child has had a psychoeducational or neuropsychoevaluational evaluation, please provide name and date of evaluation and briefly describe major findings (no need to list strengths, challenges if they are the same as list above), such as diagnosis and any accommodations.

Does your child have an IEP or 504 plan at their school?

Has your child ever worked with a tutor, psychotherapist, occupational therapist, physical therapist or other professional that would be relevant to my work with them ?

Does your child have any medical issue, past or present, that might be relevant to my work with them?

I have read the policies found on the "Policies page," and, if I should engage the services of Epstein Education, I agree to the terms stated therein.

Name _____ (by signing your name you agree to the above).

Date _____