

We are asking the parents/guardians of new students/trainees to share with us their knowledge of their child, so we can better understand and help him/her. **ALL INFORMATION IS VOLUNTARY AND WILL BE HELD IN STRICT CONFIDENCE.**

Date of intake: _____

Student/trainee name: _____

Address: _____

Telephone: _____

Date of birth: _____ Place of birth: _____

US Citizen? Yes No

Competent: _____ Guardian: _____

Primary language: _____

Preferred mode of communication:
 Speech Sign
 Gestures Communication Board

Names and addresses of people to contact in case of emergency:

1) _____
Name Relationship to student/trainee

2) _____
Name Relationship to student/trainee

Student/trainee's social security number: _____

Public Aid #/Insurance Policy #:

FAMILY BACKGROUND

(Enclose in parenthesis if not living at home)

Mother

Name: _____

Name DOB School

Address: _____

Telephone: _____

Occupation: _____

Employer: _____

Address: _____

Telephone: _____

Annual Income: _____

Father

Name: _____

Address: _____

Telephone: _____

Occupation: _____

Employer: _____

Address: _____

Telephone: _____

Annual Income: _____

Guardian

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Brothers and Sisters

Esperanza Community Services

520 North Marshfield Avenue

Chicago, IL 60618

Phone: (312)243-6097 Fax: (312)243-2076 Web: www.esperanzacommunityservices.org

State relationship

Occupation: _____

Employer: _____

Address: _____

Telephone: _____

Others in household

School history

Name of School

Year Attended

Name of School

Year Attended

Name of School

Year Attended

Name of School

Year Attended

Referred by: _____

Social Worker: _____

1) What are the reasons that you are seeking a new school/program for this individual?

2) What special concerns do you have about this individual?

3) Are there any services related to this individual with which you need assistance?

4) How old was this individual when you first became concerned about his/her development?

Explain:

5) When was this individual able to?

Sit unaided?

Walk unaided?

Reach out?

Smile?

Say a single word?

Say a single sentence?

6) What is this individual's hand preference?

7) Please circle YES /NO in response to the following questions:

Social Skills

Does this individual:

- Make eye contact? YES /NO

Esperanza Community Services

520 North Marshfield Avenue

Chicago, IL 60618

- Respond to hearing own name?
YES /NO
- Cooperate with parents request at least 50% of the time? **YES /NO**
- Imitate adults or children in simple tasks?
YES /NO
- Work alone at a task for 20 minutes?
YES /NO
- Actively explore the environment?
YES /NO
- Imitate adult roles? **YES /NO**
- Initiate contact with others? **YES /NO**
- Join in conversation with others?
YES /NO
- Share objects or food when requested?
YES /NO
- Engage in any dangerous or violent behaviors? **YES /NO**

Self help skills
Does this individual:

- Eat with a spoon? **YES / NO**
- Put own shoes on? **YES / NO**
- Eat with a fork? **YES / NO**
- Zip and snap pants? **YES / NO**
- Drink from a cup? **YES / NO**
- Button shirt? **YES / NO**
- Pull a shirt over his/her head? **YES / NO**
- Use the toilet alone? **YES / NO**
- Does he/she wear diapers? **YES / NO**

Academic
Can this individual

- Count to ten? **YES / NO**
- Read a simple sentence? **YES / NO**
- Say the alphabet? **YES / NO**
- Perform simple addition or subtraction problems? **YES / NO**
- Print his/her own name? **YES / NO**

Esperanza Community Services

520 North Marshfield Avenue

Chicago, IL 60618

Phone: (312)243-6097 Fax: (312)243-2076 Web: www.esperanzacommunityservices.org

Speech and language
Does this individual:

- Communicate through gestures or sounds? **YES / NO**
- Say his/her name? **YES / NO**
- Respond to a one step request? **YES / NO**
- Speak in an understandable way? **YES / NO**
- Point to an object upon request? **YES / NO**
- Say a complete sentence? **YES / NO**
- Communicate using sign language? **YES / NO**
- Carry on a conversation? **YES / NO**

Home Life

Please list the activities this individual engages in while at home.

- Dies he/she need constant visual supervision? **YES / NO**
- At what time does he/she go to sleep? **YES / NO**
- Does he/she wake up during the night? **YES / NO**
- Does he/she roam through the house at night while others are asleep? **YES / NO**
- What foods does he/she most like? Please list.

- What food does he/she dislike? Please list.

Medical History

- Was mother’s pregnancy normal?
YES / NO
 - Was a doctor seen on a regular basis?
YES / NO
 - Do you know of any hereditary or congenital conditions among members of parents’ families? **YES / NO**
 - Has this individual ever had a seizure? **YES / NO**
 - Has he/she ever been exposed to lead poisoning? **YES / NO**
 - Describe any falls, accidents, sudden fevers, or major illnesses that you may have had (include age of individual):
-
-
-

- Please list any allergies this individual may have:
-
-
-

- Does this individual have any other major medical concern? **YES / NO**
 - What is the name and telephone number of this individual’s doctor
-
-

- Name of hospital with which the doctor is affiliated.

To be fill out by Esperanza Staff

Follow up:

Comments:

Needs Summary:

Needs Recommendations:
