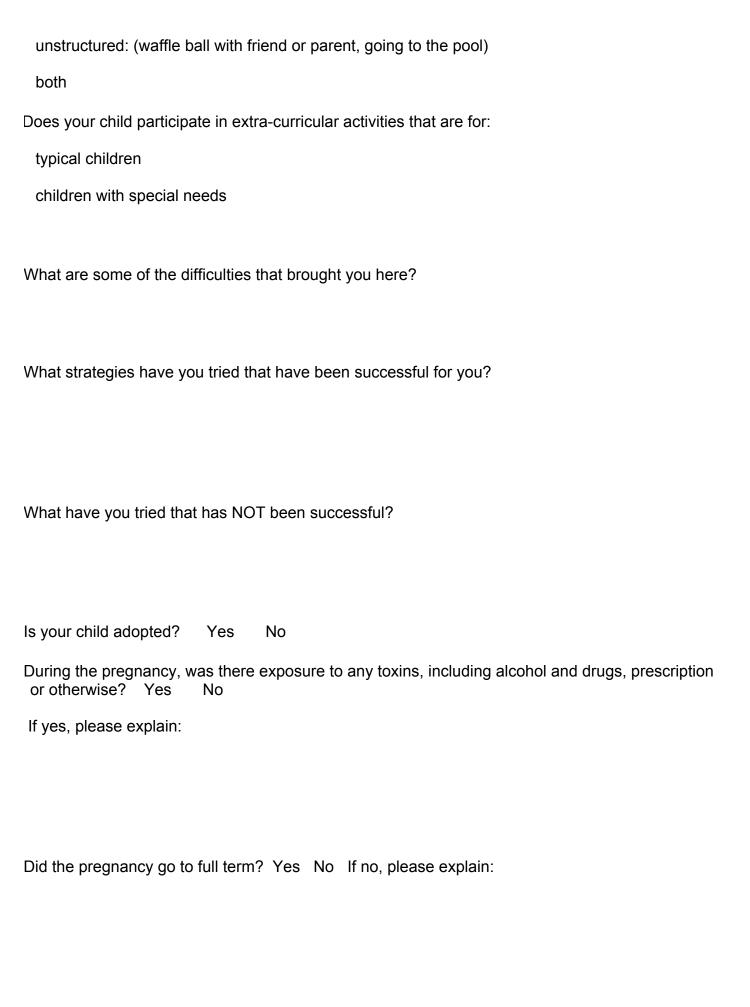
2019 Compass Intake Form

Therapist:					
Patient Demographic Information					
Patient Name:					
Street Address:	Date of Birth:				
City, State, Zip Code:	Home Phone:				
Gender:	Work Phone:				
Email Address:	Mobile Phone:				
Primary Physician:	Psychiatrist (if any):				
Emergency Contact Person:	Emergency Contact Phone:				
How did you hear about us?	Marital Status:				
Parents (Or Legal Guardians):				
Marital Status:	Home Phone:				
Street Address:	Work Phone:				
City, State, Zip Code:	Mobile Phone:				
Relationship to Patient:	Email:				
Mother or Legal Guardian:					
Name:	Home Phone:				
Street Address:	Work Phone:				
City, State, Zip Code:	Mobile Phone:				
Relationship to Patient:	Email:				
Father or Legal Guardian:	<u> </u>				
Name:	Home Phone:				
Street Address:	Work Phone:				

O:t : Otata 7:	- O-d		Mahila Dhana.
City, State, Zip Code:			Mobile Phone:
Relationship to Patient:			Email:
Who are the μ	people most invo	lved in your child's care	e?
Mother	Father	Grandparents	Housekeeper (au Pair)
Other:			
Primary langua	age(s) spoken in	the home:	
Please tell us a agencies, etc.)		ort network (i.e. family, t	friends, support groups,
If an agency or	r licensed profes	sional, please include n	names and phone numbers for each.
What are your	child's strengths	?	
	r child's favorite vatching, TV, cra		computer games, sports activities, reading, playing
		xtra-curricular activities	
	pe (baseball, so		·

Are extra-curricular activities: structured: (little league, soccer team, dance class, swim team or class)



At what age did ye	our child:		
Sit up	Crawl	Walk	Speak in sentences
Is your child toilet	trained? Yes	No At what age?	
		nges in your family? f a sibling, difficulties	(death of a family member, disruption of family s with siblings)
•	-	_	is experiencing (i.e. difficulty learning to read, hers or classmates)
Please explain an	ıy social difficult	ies your child is exp	eriencing:
		MEDICAL IN	FORMATION
What is your child	l's most current	diagnosis?	
Did your child eve	er receive anoth	er diagnosis?	
Is your child on m	edication? Yes	s No	
If YES, what type	(s) and dosage?	?	
Does your child h	-		all surgeries (and dates)

Has your child ever been hospitalized for an extended period of time? Yes No

Cause of hospitalization:

Does your child have a history of seizures? Yes No

When was his/her last seizure?

Approximately how frequently does your child have seizures?

Is your child currently under the care of a psychiatrist/ psychologist/ social worker? Yes No

If yes, which:

How frequently (i.e. 1x month, 1x week, 2x month)

Does your child have health insurance? Yes No

If YES, what type?

SCHOOL INFORMATION

Does your child go to public or private school?

Does your child have an Individual Education Plan (IEP)? Yes No

Does your child attend a special education school? Yes No

What type of classroom is your child in? Mainstream Inclusion Self-contained

Other:

Does your child have an aide? Yes No

If YES, what is the child to aide ratio? (i.e. 3:1, three children share one aide)

Does you child use any adaptive equipment in the classroom? Yes No

Does your child have attendance difficulties? Yes No

Please describe anything else that you think would help us to understand your child: