HALO BEHAVIORAL HEALTH

# INTAKE QUESTIONNAIRE

## *Office Use Only*

| | |
|---|---|
| Date: _____ | Interviewer: _____ |
| Time: _____ | Interviewee: _____ |

## Client Information

| | | | |
|---|---|---|---|
| Legal Last Name: | Legal First Name: | Legal Middle Name: | Nickname: |
| Date of Birth: | Age: _____ years _____ months | Social Security: | |
| Gender: | | Ethnicity: | |
| Primary Address: | | Primary Phone: | |
| City, State, Zip: | | Primary Email: | |

Referral Source:

☐ Insurance Provider ☐ Physician ☐ School ☐ Event

☐ Advertisement ☐ Family ☐ Friend ☐ Conference

☐ Internet ☐ Press ☐ Other:

| | |
|---|---|
| Primary Reason for Referral: (*Please describe the problems your child is now having and what type of services you are seeking from us for these problems*). | |

## Emergency Contact

| | | | |
|---|---|---|---|
| Last Name: | First Name: | Relationship: | |
| Home Phone: | Cell Phone: | Work Phone: | Preferred: ☐ Home ☐ Cell ☐ Work |

## Health Care Coverage

| | | |
|---|---|---|
| Desired coverage for services provided? | ☐ Private Pay | ☐ Health Insurance |

### Primary Health Insurance Coverage

| | | |
|---|---|---|
| Insurance Provider Name: | | Insurance Provider Phone Number: |
| Policy Identification Number: | | Group Number: |
| Subscriber Name: | Subscriber Employer: | Subscriber Relationship to Client: |
| Subscriber Date of Birth: | | Subscriber Social Security Number: |

### Secondary Health Insurance Coverage

| | | |
|---|---|---|
| Insurance Provider Name: | | Insurance Provider Phone Number: |
| Policy Identification Number: | | Group Number: |
| Subscriber Name: | Subscriber Employer: | Subscriber Relationship to Client: |
| Subscriber Date of Birth: | | Subscriber Social Security Number: |

**Please attach a copy of the insurance card(s).**

## Client Availability (Scheduling Services)

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 7:30am | | | | | | | |
| 8:00am | | | | | | | |
| 9:00am | | | | | | | |
| 10:00am | | | | | | | |
| 11:00am | | | | | | | |
| 12:00pm | | | | | | | |
| 1:00pm | | | | | | | |
| 2:00pm | | | | | | | |
| 3:00pm | | | | | | | |
| 4:00pm | | | | | | | |
| 5:00pm | | | | | | | |
| 6:00pm | | | | | | | |
| 6:30pm | | | | | | | |

## *Current* Client Diagnostic Information

### All Current Physicians

| Physician Name: | Specialty: | Contact Number: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

### Psychological

| Current Diagnoses: | Diagnosing Physician: | Treating Physician: | Date of Diagnosis: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please attach diagnostic report(s).**

### Medical

| Current Conditions: | Diagnosing Physician: | Treating Physician: | Date of Diagnosis: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

### All Current Medications
(*Including Vitamins or Supplements*)

| Name: | Dosage: | Frequency: | Use: | Side Effects: | Prescriber: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## *Previous* Client Psychological and Medical History

### Psychological

| Previous Diagnoses: | Diagnosing Physician: | Date Provided: | Date Removed: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Has your child ever had suicidal ideation? ☐ Yes ☐ No

| If **yes**, please describe in detail: | |
|---|---|

### Medical

| Previous Diagnoses: | Diagnosing Physician: | Date Provided: | Date Removed: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had:**

### *Medications*

| Name: | Dosage: | Frequency: | Use: | Side Effects: | Prescriber: | Use Duration: |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| ***Testing*** | | | |
|---|---|---|---|
| Has your child had any of the following medical tests conducted and if so, what was the outcome? | | | |
| **Test:** | **Yes:** | **No:** | **Outcome:** |
| Hearing | ☐ | ☐ | |
| Vision | ☐ | ☐ | |
| MRI / Brain Scan | ☐ | ☐ | |
| Genetic Testing | ☐ | ☐ | |
| Allergy Testing | ☐ | ☐ | |

| ***Treatment*** | | |
|---|---|---|
| Is your child up to date on **all** of his / her vaccinations? | ☐ Yes | ☐ No |
| Does your child regularly visit his / her pediatrician or primary care physician? | ☐ Yes | ☐ No |
| Does your child regularly visit a dentist? | ☐ Yes | ☐ No |
| Does your child regularly visit an optometrist? | ☐ Yes | ☐ No |
| Does your child regularly visit an audiologist? | ☐ Yes | ☐ No |

## Client Developmental History

### Prenatal and Delivery

| | | | |
|---|---|---|---|
| Were there any complications during **pregnancy**? | | ☐ Yes | ☐ No |
| If **yes**, please describe complications and any corresponding treatment details: | | | |
| Was birth at full term? | | ☐ Yes | ☐ No |
| If **no**, please describe in detail: | | | |
| Delivery**:** ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section ☐ Other: | | | |
| Birth Weight: | pounds ounces | Birth Height: | inches |
| Were there any complications during **delivery**? | | ☐ Yes | ☐ No |
| If **yes**, please describe complications and any corresponding treatment details: | | | |

| Were there any concerns **post-delivery**? | ☐ Yes | ☐ No |
|---|---|---|
| If **yes**, please describe complications and any corresponding treatment details: | | |

## Postnatal and Developmental

| Were there any significant illnesses during your child's **first year**? | ☐ Yes | ☐ No |
|---|---|---|
| If **yes**, please describe complications and any corresponding treatment details: | | |

| Milestones | Estimated Age of Onset: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 4M | 6M | 9M | 1Y | 1.5Y | 2Y | 3Y | 4Y | 5Y | N/A |
| Babbling. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Holding head up (unsupported). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stringing vowels together (e.g., "ah," "eh," "oh"). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Making consonant sounds (e.g., jabbering with "m," "b"). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Rolling over consistently in both directions (front – back, back – front). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Using finger to point at things. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pulling to stand and stand (when holding on). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sitting up (unsupported). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Crawling. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Saying at least one single word(s) (intelligible to others). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cruising (i.e., walking while holding onto furniture). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Saying several single word(s) (intelligible to others). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walking (unassisted). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Saying first two-word phrase(s) intelligible to others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Saying first three-word phrase(s) intelligible to others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Standing on tiptoe. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Running. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Climbing onto and down from things (unassisted). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walking up and down stairs (one foot per each step). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Using sentences regularly in speech. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Speaking very clearly and can carry on conversations with others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Toilet trained. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

# Client Educational Information

## Current

| Name of School: | | | Years Attended: |
|---|---|---|---|
| Address: | | Phone: | |
| City, State, Zip: | | Email: | |
| School District: | | School Type: | |
| Principal Name: | Teacher(s) Name(s): | Teacher Aide(s) Name(s): | |
| Grade: | Placement: | Number of Students: | Weekly Hours in School: |

Has your child ever had, or does he / she currently have, any of the following within his or her school setting? (Please check all that apply).

☐ Functional Behavior Assessment ☐ Behavior Intervention Plan

☐ Individualized Education Plan ☐ Other: _____

**Please attach all supporting educational documents.**

Does your child's teacher have concerns about him / her and his / her performance?

☐ Yes ☐ No

**Please Describe**:

Does this school provide your child with a one-to-one aide in his or her classroom?

☐ Yes ☐ No

**Comment**:

Do you believe this school is meeting your child's academic needs? ☐ Yes ☐ No

**Please Describe**:

## History

| Name of School: | | Years Attended: |
|---|---|---|
| Address: | Phone: | |
| City, State, Zip: | Email: | |
| School District: | School Type: | |

# Other Treatment Providers

## Current Services

| Type: | Contact: | Location: | | Start Date: | Hours: | Outcomes: | |
|---|---|---|---|---|---|---|---|
| | | Home | School | | | Satisfied | Unsatisfied |
| Behavior Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Psychotherapy | | ☐ | ☐ | | | ☐ | ☐ |
| Speech Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Occupational Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Physical Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Social Skills | | ☐ | ☐ | | | ☐ | ☐ |
| Other: _____ | | ☐ | ☐ | | | ☐ | ☐ |

## Previous Services

| Type: | Contact: | Location: | | Dates of Treatment: | Hours: | Outcomes: | |
|---|---|---|---|---|---|---|---|
| | | Home | School | | | Satisfied | Unsatisfied |
| Behavior Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Psychotherapy | | ☐ | ☐ | | | ☐ | ☐ |
| Speech Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Occupational Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Physical Therapy | | ☐ | ☐ | | | ☐ | ☐ |
| Social Skills | | ☐ | ☐ | | | ☐ | ☐ |
| Other: _____ | | ☐ | ☐ | | | ☐ | ☐ |

**Please attach most recent supporting documents (e.g., evaluation, initial report, progress report, etc.)**

# Daily Living

## Ecological Arrangements

| Primary Language(s) Spoken in Home: | Child's Extracurricular Activities: |
|---|---|

**Please describe any cultural, religious, ethnic, or social beliefs about physical or mental health or illness that you feel would help us in understanding your child and family**:

| Confidence and Success during Community Outings: ☐ Good ☐ Fair ☐ Poor | Exclusive Room(s) / Space(s) for Conducting Therapy: ☐ Yes ☐ No | Exclusive Table for Conducting Therapy: ☐ Yes ☐ No |
|---|---|---|
| ***Notes***: | ***Notes***: | ***Notes***: |
| Lighting in the Home: ☐ Bright ☐ Moderate ☐ Dim | Noise Level in the Home: ☐ Loud ☐ Moderate ☐ Quiet | Commotion in the Home: ☐ High ☐ Moderate ☐ Low |
| ***Notes***: | ***Notes***: | ***Notes***: |
| Access to Toys: ☐ Free ☐ Restricted ☐ Mixed | Access to Food: ☐ Free ☐ Restricted ☐ Mixed | Access to Electronics: ☐ Free ☐ Restricted ☐ Mixed |
| ***Notes***: | ***Notes***: | ***Notes***: |

***List All Individuals <u>Currently</u> Living in the Home of the Child:***

| Name: | Relationship: | Age: | Gender: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

***List All Individuals Significant to Your Child, but <u>NOT</u> Currently Living in Their Home:***

| Name: | Relationship: | Age: | Gender: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

# Functional Behavior Assessment Interview

## Sleep Disturbances

How would you describe the quality of your child's sleep? ☐ Good ☐ Fair ☐ Poor

| If **fair or poor**, please describe: | |
|---|---|

| Eating Patterns | | | |
|---|---|---|---|
| How would you describe your child's food consumption? | ☐ Good | ☐ Fair | ☐ Poor |
| Is your child a picky eater? | ☐ Yes | ☐ No | |
| Is your child on any special diet? | ☐ Yes | ☐ No | |
| If consumption is **fair or poor**, or if a **picky eater** or on a **special diet**, please describe: | | | |

| Motor Dysfunction | | | |
|---|---|---|---|
| How would you describe your child's gross motor functioning? | ☐ Good | ☐ Fair | ☐ Poor |
| How would you describe your child's fine motor functioning? | ☐ Good | ☐ Fair | ☐ Poor |
| If either is **fair or poor**, please describe: | | | |

| Problem Behavior | |
|---|---|
| **Briefly describe how your child's behaviors would be affected under the following conditions.** | |
| Asked to perform a difficult task: | |
| Interrupted a desired activity: | |
| Unexpected change in routine: | |

| | |
|---|---|
| Denied something he wanted: | |
| Not given attention / left alone for a long period of time: | |

| **Strategies** | |
|---|---|
| ***Successful*** | ***Unsuccessful*** |
| | |

| **Strengths** |
|---|
| |

# Reinforcement Inventory

Fisher, Piazza, Bowman, & Amari (1996)

## Visual Stimuli

| | | |
|---|---|---|
| Does your child enjoy looking at things such as mirrors, bright lights, shiny objects, spinning objects, YouTube videos, television, etc.? | ☐ Yes | ☐ No |
| Please describe all visual stimuli your child **most** likes to watch: | | |

## Auditory Stimuli

| | | |
|---|---|---|
| Does your child enjoy different sounds such as cars, nature, whistles, beeping noises, sirens, clapping, music, podcasts, audiobooks, social praise, etc.? | ☐ Yes | ☐ No |
| Please describe all auditory stimuli your child **most** likes to listen to: | | |

## Olfactory Stimuli

| | | |
|---|---|---|
| Does your child enjoy different smells such as essential oils, pine trees, flowers perfume, coffee, laundry detergent, candles, etc.? | ☐ Yes | ☐ No |
| Please describe all olfactory stimuli your child **most** likes to smell: | | |

## Gustatory Stimuli

| | | |
|---|---|---|
| Does your child enjoy particular foods or snacks such as candy, ice cream, pizza, juice, smoothies, graham crackers, chips, fruit, McDonald's, etc.? | ☐ Yes | ☐ No |
| Please describe all gustatory stimuli your child **most** likes to eat: | | |

## Proprioceptive Stimuli

| | | |
|---|---|---|
| Does your child enjoy physical play or movement such as being tickled, hugs, pats on the back, high fives, wrestling, running, dancing, swinging, etc.? | ☐ Yes | ☐ No |
| Please describe all proprioceptive stimuli your child **most** likes: | | |

| Tactile Stimuli | | |
|---|---|---|
| Does your child enjoy touching things of different temperatures (e.g., cold things like snow or an ice pack, or warm things like a hand warmer or cup containing hot tea or coffee) or textures (e.g., smooth, rough, or slippery)? | ☐ Yes | ☐ No |
| Does your child enjoy feeling different sensations such as splashing water in a sink, a vibration against the skin, air blown on the face from a fan, etc.? | ☐ Yes | ☐ No |
| Please describe all tactile stimuli your child **most** likes: | | |

| Tangible Stimuli | | |
|---|---|---|
| Does your child enjoy certain toys, objects, or activities, such as puzzles, bubbles, blocks or Legos, dolls, computer or video games, tablet applications, arts and crafts, etc.? | ☐ Yes | ☐ No |
| Please describe all tangible stimuli your child **most** likes to play or to play with: | | |

| Other | |
|---|---|
| Please describe any other things that your child **most** likes: | |

***Hierarchical Ranking of Stimuli:***

| | Highest Preferred | Moderately Preferred | Lowest Preferred |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

| ***Please list any items you would <u>not</u> like used:*** | ***Please list any items you would like used in <u>moderation</u>:*** |
|---|---|
| | |

***Please list any items you would <u>not</u> want restricted for use within the context of treatment:***

## Current Custody Agreement

| | | | | |
|---|---|---|---|---|
| Parents Are: | ☐ Married | ☐ Separated | ☐ Divorced | ☐ Widowed |
| | ☐ Remarried | ☐ Cohabitants | ☐ Single | ☐ Other: |
| Custodial Arrangement: | ☐ Joint | ☐ Shared | ☐ Alternating | ☐ Bird's Nest |
| | ☐ Sole | ☐ Split | ☐ Third Party | ☐ Other: |

**Please Explain in Detail**:

**Attach Legal Custody Agreement.**

## Legal Guardian Information

### Mother

| | | | |
|---|---|---|---|
| Last Name: | First Name: | Nickname: | |
| Date of Birth: | | Social Security: | |
| Ethnicity: | | Language(s) Spoken: | |
| Address (**if different from child**): | | City, State, Zip: | |
| Home Phone: | Cell Phone: | Work Phone: | Preferred: ☐ Home ☐ Cell ☐ Work |
| Fax: | Email: | | Preferred: ☐ Fax ☐ Email |
| Occupation: | Employer: | Highest Education Degree: | |
| Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor | | Percentage of Time Spent with Client: | |

### Father

| | | | |
|---|---|---|---|
| Last Name: | First Name: | Nickname: | |
| Date of Birth: | | Social Security: | |
| Ethnicity: | | Language(s) Spoken: | |
| Address (**if different from child**): | | City, State, Zip: | |

| Home Phone: | Cell Phone: | Work Phone: | Preferred: ☐ Home ☐ Cell ☐ Work |
|---|---|---|---|
| Fax: | Email: | | Preferred: ☐ Fax ☐ Email |
| Occupation: | Employer: | Highest Education Degree: | |
| Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor | Percentage of Time Spent with Client: | | |

## Third Party

| Last Name: | First Name: | Nickname: |
|---|---|---|
| Date of Birth: | Social Security: | |
| Ethnicity: | Language(s) Spoken: | |
| Address (**if different from child**): | City, State, Zip: | |

| Home Phone: | Cell Phone: | Work Phone: | Preferred: ☐ Home ☐ Cell ☐ Work |
|---|---|---|---|
| Fax: | Email: | | Preferred: ☐ Fax ☐ Email |
| Occupation: | Employer: | Highest Education Degree: | |
| Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor | Percentage of Time Spent with Client: | | |

## Stepmother

| Last Name: | First Name: | Nickname: |
|---|---|---|
| Ethnicity: | Language(s) Spoken: | Percentage of Time Spent with Child: |

| Home Phone: | Cell Phone: | Work Phone: | Preferred: ☐ Home ☐ Cell ☐ Work |
|---|---|---|---|

## Stepfather

| Last Name: | First Name: | Nickname: |
|---|---|---|
| Ethnicity: asdfasdf | Language(s) Spoken: | Percentage of Time Spent with Child: |

| Home Phone: | Cell Phone: | Work Phone: | Preferred: ☐ Home ☐ Cell ☐ Work |
|---|---|---|---|

# Family Psychological and Medical History

## Family Psychological

| Diagnosis: | Yes: | No: | Who? | Current? Yes: | Current? No: |
|---|---|---|---|---|---|
| Intellectual Disability | ☐ | ☐ | | ☐ | ☐ |
| Communication Disorder | ☐ | ☐ | | ☐ | ☐ |
| Autism Spectrum Disorder | ☐ | ☐ | | ☐ | ☐ |
| Attention-Deficit / Hyperactivity Disorder | ☐ | ☐ | | ☐ | ☐ |
| Specific Learning Disorder | ☐ | ☐ | | ☐ | ☐ |
| Motor or Tic Disorder | ☐ | ☐ | | ☐ | ☐ |
| Psychotic Disorder | ☐ | ☐ | | ☐ | ☐ |
| Bipolar Disorder | ☐ | ☐ | | ☐ | ☐ |
| Depressive Disorder | ☐ | ☐ | | ☐ | ☐ |
| Anxiety Disorder | ☐ | ☐ | | ☐ | ☐ |
| Obsessive-Compulsive Disorder | ☐ | ☐ | | ☐ | ☐ |
| Trauma- or Stressor-Related Disorder | ☐ | ☐ | | ☐ | ☐ |
| Dissociative Disorder | ☐ | ☐ | | ☐ | ☐ |
| Feeding or Eating Disorder | ☐ | ☐ | | ☐ | ☐ |
| Substance Related or Addictive Disorder | ☐ | ☐ | | ☐ | ☐ |
| Neurocognitive Disorder | ☐ | ☐ | | ☐ | ☐ |
| Personality Disorder | ☐ | ☐ | | ☐ | ☐ |
| Other: | ☐ | ☐ | | ☐ | ☐ |

**Other Family Conditions that May Affect Clinical Treatment:**

☐ Relational ☐ Educational ☐ Occupational ☐ Housing ☐ Financial ☐ Social ☐ Criminal / Legal

**Please describe above in further detail**:

| Family Medical | | | | | |
|---|---|---|---|---|---|
| **Diagnosis:** | **Yes:** | **No:** | **Who?** | **Current?** | |
| | | | | **Yes:** | **No:** |
| Acid Reflux | ☐ | ☐ | | ☐ | ☐ |
| Asthma | ☐ | ☐ | | ☐ | ☐ |
| Autoimmune Disorder | ☐ | ☐ | | ☐ | ☐ |
| Birth Defect / Congenital Anomaly | ☐ | ☐ | | ☐ | ☐ |
| Diabetes | ☐ | ☐ | | ☐ | ☐ |
| Food Allergies | ☐ | ☐ | | ☐ | ☐ |
| Genetic Disorder | ☐ | ☐ | | ☐ | ☐ |
| Hearing Disorder | ☐ | ☐ | | ☐ | ☐ |
| Irritable Bowel Disorder | ☐ | ☐ | | ☐ | ☐ |
| Migraine / Headaches | ☐ | ☐ | | ☐ | ☐ |
| Scoliosis | ☐ | ☐ | | ☐ | ☐ |
| Seizure Disorder | ☐ | ☐ | | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | | ☐ | ☐ |
| Vision Problems | ☐ | ☐ | | ☐ | ☐ |
| Other: | ☐ | ☐ | | ☐ | ☐ |

## Documents Requested:

- **Health Insurance Card**
- **Psychological Diagnostic Report**
- **Educational Reports**
- **Other Treatment Provider Reports**
- **Legal Custody Agreement (if applicable)**