Parkaire Consultants, Inc.

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The information you provide us will help us understand your problems and can be released only with your consent.

Date: ______________________ Referred by: ______________________

Client Name: ______________________ DOB: __________ Age: ____
Last First Middle

Address: ______________________ City: ______________________

State: ________ Zip: __________ Home Phone: ______________________ Male: ______ Female: ______

Mom Cell: ______________ Dad Cell: ______________ Client Cell: ______________

E-mail Address (parent & client): ______________________

School: ______________________ Grade: ______

Teachers: ______________________

List all people living in household with client: include siblings, step-children, other relatives, foster children, friends, etc.

Name	Relationship to Client	Age	Unusual Problems (i.e. coordination, behavior, emotional problems, etc.)

Client's marital status: ❒N/A ❒Single ❒Married ❒Separated ❒Divorced ❒Widowed ❒Other

Client's parents marital status: ❒Single ❒Married ❒Separated ❒Divorced ❒Widowed ❒Other

Client's/Parents/Guardian employer: ______________________ Phone: ______________

Diagnosis: ______________________

Please list medications client is currently taking.

Med/Dosage	Condition Requiring Meds	Doctor Who Prescribed Meds	Doctor's Phone	Date Meds Started

OVER

Please list any therapies client is currently receiving: ____________________

Is the client currently having school problems? ❒Yes ❒No

If yes, explain: ____________________

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Is the client currently having work/social difficulties? ❒Yes ❒No

If yes, explain: ____________________

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Please check any special services client has received:

- ❒ LD Resource
- ❒ LD Self-contained
- ❒ BD Resource
- ❒ BD Self-contained
- ❒ MI Resource
- ❒ MI Self-contained
- ❒ MO Self-contained
- ❒ Hearing Impaired Resource
- ❒ Hearing Impaired Self-contained
- ❒ Speech/language Therapy
- ❒ Audiology Services
- ❒ Visual Therapy
- ❒ Occupational Therapy
- ❒ Physical Therapy
- ❒ Adaptive Physical Education
- ❒ Orthopedic Handicapped Services
- ❒ Handicapped Kindergarten
- ❒ Gifted Program
- ❒ Other Health Impaired
- ❒ Remedial Help
- ❒ Tutoring
- ❒ Other: ____________________

Please give a comprehensive statement of your concerns, listing those of greatest importance first:

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Approximate date the current problem began: ____________________

Has the problem gotten worse, gotten better, or stayed the same since it began? Please be specific.

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Please describe any particular disorder or problem that preceded the current difficulty and might have been associated with its onset.

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Who felt the client should be seen at this time? ____________________