

Social Groups Application Form and Parent Questionnaire Form

I. Identifying Information

Child's Name _____ Nickname _____ Age _____

Birth date _____ Male _____ Female _____

Child's Home Address: _____

Name of Parent/Guardian _____

Relationship to child _____ Occupation: _____

Phone: Home () _____ Work or Cell () _____

Name of Parent/Guardian _____

Relationship to child _____

Address (if different than above): _____

Occupation: _____

Phone: Home () _____ Work or Cell () _____

Who does your child live with? (Check all that apply.)

- both parents grandparents mother only foster parents
 father only parent + stepparent other _____

Are languages other than English (including sign language) used at home? ____ yes ____ no

If Yes, what language (s)? _____

II. Referral

How did you hear about our program? _____

Is/Has your child received speech/language and/or developmental services? ____ yes ____ no

Has your child been evaluated by any other professional? (Check all that apply.)

- Speech-language pathologist educator/teacher
 Occupational therapist (OT) neurologist
 Physical therapist (PT) physician
 developmental pediatrician (specialist) geneticist
 psychologist/psychiatrist other _____

III. Home and Family

Please list siblings and other members of the household (not listed on page 1) :

Name Date of birth Age M/F Relationship to child

IV. Medical History

Name of child’s Pediatrician/Doctor _____

Phone: _____ Address _____

List any past or current health problems your child has : _____

Is your child currently on medications? Medication(s): _____

Was your child previously on any medications? Medication(s) _____

Does your child have allergies (including food)? ____yes ____no

If yes, please elaborate: _____

Do you have any concerns about your child’s eyesight? ____yes ____no

If yes, please explain: _____

Has your child ever received another medical or neurodevelopmental disorder diagnosis (ie. ADHD, depression, Oppositional Defiant Disorder)? _____

What were the behavioral symptoms that led you to bring him/her to be checked/diagnosed at that time? (Poor eye contact, delayed language development, etc) _____

Has your child had any other cognitive testing within the last 2 years? Y N

If yes, what were the results – _____e

***Please bring copies of the assessment,

V. Hearing

Yes No

___ ___ Do you feel your child hears well?

___ ___ Does he/she wear hearing aids? If Yes: Make and model _____

When did he/she receive the hearing aids? _____

___ ___ Has your child ever had a hearing test? If yes, when? _____

Results? _____

Does your child appear to attend to your face when listening? ____yes ____no

Does your child appear to become distracted easily when listening? ___yes ___no

Does your child appear to be particularly uncomfortable in noise? ___yes ___no

VI. Communication Skills and Cognition

What does your child use the most? _____ complete sentences _____ phrases _____ one or two words
_____ gestures/signs _____ augmentative communication system

Please indicate your child's level of understanding of other's by checking those that apply:

_____ understands gestures _____ does not understand spoken words _____ understands single words
_____ understands simple sentences _____ understands 2 and 3 part commands _____ understands conversation

Does your child typically display any of the following behaviors? (Check all that apply.)

- reduced or lack of interaction with others
- difficulty staying on task
- tantrums
- difficulty finishing tasks
- passive in interactions
- sensitive
- very active
- angry/acting out behavior
- underactive
- frustrated
- inattentive
- shy
- refuses to perform tasks

VII. School

Does your child attend: _____ school _____ other?

Name of school: _____ grade: _____

How does your child relate to children in their own age group? _____

Other programs your child has attended: _____

VIII. Other Questions

How would you describe your child? Reserved? Confident? Assertive? _____

How does your child react when he/she is upset or sad? _____

What is the best way to comfort him/her? _____

How does your child deal with frustration? _____

What strategies do you employ? _____

How does your child deal with separation? _____

List a few of your child's favorite activities: _____

Does your child have any pets? (Real or favorite stuffed animal) _____

What other concerns do you have about your child? _____

What do you consider to be your child's greatest strengths? _____

What do you hope for your child to gain or change as a result from participation of the social group program?

Has your child ever participated in a social skills group or another behavioral training program before?

Yes or No When _____ Where _____

How did that experience go? _____

How does your child interact with peers? _____

Does he/she have friends? _____ Do they want to have more friends? _____

Please describe your child's school experience. Please include what are they like on the playground/cafeteria?

Any behavioral problems at school? At home? Please describe your child's sensitivities a

All information will be held in strict confidence and not released to any person(s) without explicit authorization nor shared with any unauthorized person.