



Intake Form

Child is Enrolled on what days: Monday __ Tuesday __ Wednesday__ Thursday_X_ Friday__

Childs Name:

First: _____ Middle Initial: _____ Last: _____

Grade of Child: _____ School Child Attends: _____

Address: _____

Street: _____

City: _____ State: _____ Zip: _____

Primary Language: _____ Date of Birth: _____

Has child been diagnosed with Autism Spectrum Disorder? Yes or No

Has child been diagnosed with ADHD? Yes or No

Please note any known allergies:

Parents Name:

Name: _____

Address: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell Phone: _____

Email Address: _____

REASON FOR BEING HERE AT THIS TIME CURRENT PROBLEMS:

What brings you here? Please briefly describe your child's current problems starting with the most serious.

ONSET: How long ago did the problem begin? _____ How old was your child? _____

Were there any major stresses happening in the family at the time the problems began?

TREATMENT: What kinds of interventions have been tried?

Have you tried medications, seen other therapists, used any "non-traditional" treatments?

SCHOOL: Describe your child's function at school. Are there any problems? What are school related likes and dislikes?

STATEMENT OF POLICY:

Any client enrolled to receive services from Bryce's Journey, Inc., is required to follow Covid 19 guidelines. Clients with a fever or a contagious illness may not receive services until being cleared with a medical note from their health provider. **When receiving in person sessions masks must be worn at all times and 3 feet distances.** I have read and understand the Statement of Policy.

Parent Signature

Date