Child Name
Child DOB

Age 5 and Over
School Intake Questionnaire

DEAR PARENT:

Please give the attached questionnaire to your child's school guidance office.

Ask them to have the appropriate person or persons complete the form and get copies of all testing that has been done for this child.

Return all documents to our office as soon as possible, before your appointment here.

The questionnaire will be reviewed by staff at Elliot Developmental Pediatrics who will be involved in your child's evaluation.

Please attach completed reports of all assessments

- **Psychological**
- **Speech and Language**
- **Occupational Therapy**
- **Physical Therapy**
- **Educational readiness or achievement**
- **IEP**

Please call if you have any questions.
Phone: 603-663-3222

Please note that all information is kept strictly confidential.

Once the form is done and testing reports are collected the school should return all the documents to:

Elliot Developmental Pediatrics
275 Mammoth Rd
Manchester, NH 03109

Or fax to: 603-663-3229

Child Name
Child DOB

Who is completing this questionnaire?
Name ____
Title ____

Name ____
Title ____

Name ____
Title ____

DATE______________________________

Please attach completed reports of any assessments:
Psychological
Speech and Language
Occupational Therapy
Physical Therapy
Educational readiness or achievement
IEP

School District ____
Entered this school district grade ____
Current school year and grade ____

Has the child repeated a grade? Yes No If yes which grade? ____________________
Why? ____

Academic Achievement

Class	Current Level	Test Used	Report card Grade	State Test Results
Math				
Reading				
Writing				

WHAT QUESTIONS WOULD YOU LIKE ANSWERED? ______________________________

____

What are this child's strengths?____

What are this child's challenges?____

Does the current program meet these needs?_____________________________________

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Has the child been referred to the Committee on Special Education? Yes No
Referral dates and outcomes ____

Does this child have a 504 plan? Yes No
Date ____
Diagnosis____
Annual review date______________________________--

Does this child have an IEP? Yes No
Date ____
Annual review date ____
Date for re-assessment
Program is (Circle): school year only extended year/summer program

IEP classification /designation: 1)___________________2)_____________________

Current placement
General education class with _________ # students
General education with push in support staff ___________________________
Inclusion class with _______ # students
Resource room outside of regular classroom____________________________
Self-contained class____
Student to teacher ratio____

Curriculum is modified Yes/ No Please describe:__________________________
____
____

Services provided Please indicate all that apply

	Building level	Date started	Push in/pull out	frequency (min/week)	indiv/group
Speech					
OT					
PT					
Counseling					

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Social skills					
Accommodations					
Classroom Aid					

Special education

	RTI	Date Started	Tier 1	Tier 2	Tier 3
Reading					
Math					
Writing					

Does this student have an FBA Functional Behavior Assessment or Intervention Plan? Yes No
Date ____
Target Behaviors ____
Rewards ____

PLEASE COMMENT ON CURRENT SKILLS IN:
1) *Communication*

Verbal expression ____

Comprehension (follows directions) ________________________________

____

Verbal processing ____

____

2) *Motor skills*____

Hand writing ____

Gross motor ____

3) *Organization*

____

____

Child Name
Child DOB

4) *Behaviors that are concerning*
____

____

5) *Peer Interaction*
____

____

6) *Home environment*
____

PLEASE ATTACH FULL REPORTS OF ALL TESTING COMPLETED FOR THIS CHILD.

Please return this as soon as possible to
Elliot Pediatric Specialties
Developmental Pediatrics
275 Mammoth Rd
Suite One
Manchester NH 03109

Or fax to 603 663 3229

THANK YOU