



WHEELS OF WELLNESS INTAKE FORM

PLEASE COMPLETE EACH CELL WITH AS MUCH INFORMATION AS POSSIBLE

Child Information	Today's Date:		
Last Name:	Age:	yrs	months
First Name:	Date of Birth:		
Home phone:			
Address:			
City:			
State:	Zip code:	County:	Country:
How were you referred to WHEELS OF WELLNESS?			

Primary Diagnosis:	Date of Diagnosis:
Secondary Diagnosis:	Date of Diagnosis:
Other condition:	Date of Diagnosis:

Legal Guardian Information	
Full Name:	Relationship to Child:
Address: (if different from applicant)	
City:	
State:	
Home Phone: (if different from applicant)	
Cell Phone:	E-mail:

Legal Guardian Information	
Full Name:	Relationship to Child:
Address: (if different from applicant)	
City:	
State:	
Home Phone: (if different from applicant)	
Cell Phone:	E-mail:

Applicant's Siblings:		
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

Present School/Placement:	Teacher's Name:
Name of School:	Years attended:
Address:	Placement:
Phone:	IEP/504 Plan

Are there any medical conditions that need to be considered when working with your child?	Yes No If yes, please explain:

Supportive Services

What other services is your child currently receiving both in-school and out of school? Please enclose a copy of any document that can assist Wheels of Wellness with better understanding your child. (IEP, IFSP, Behavior Support Plan, Psychological Assessment, evaluation, etc.)

Service/Therapy	Location	Minutes/Week
Early Intervention Services	School Home	
Speech and/or language therapy	School Home	
Occupational Therapy	School Home	
Physical Therapy	School Home	
Other	School Home	
Other	School Home	
Other	School Home	

What is your main goal for Services?

What current communication skills does your child have? Ex., sign language, PECS, verbal, please explain:

If you are seeking academic support (reading/comprehension, handwriting, spelling, etc) please describe your child's current strengths and challenges.

What are your child's abilities, interests or quirks that make him/her unique? Please include any sensitivities or sensory challenges (loud sounds, textures, need for frequent sensory breaks, etc)

Describe your child's demeanor (ex: quiet, shy, introvert or silly, talkative, extrovert). When is your child happiest? Please include favorite games, toys, characters, music, rituals, etc. What are the best motivators for your child?

Please share any additional information that may be important or considered when working in your home with your family including cultural or religious considerations, other persons living or working in your home, pets, etc.