



WEB INTAKE INQUIRY							
Parent Last Name		First		Date Completed			
Other Parent/ Guardian Names			Guardian's Relationship				
Other Parent/ Guardian Names			Guardian's Relationship				
Street Address			Apartment/Unit #				
City		Prov		PC			
Phone		E-mail Address					
Circle Your Preferred Mode of Communication?		Email	OR	Phone	Best time(s) to reach you?		
CHILD'S NAME		AGE		Date of Birth			
Sibling name(s) & ages?	#1	#1 AGE		#2		#2 AGE	
Reason for seeking Specialized Services?							
Has your child received a diagnosis?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, what were the results?				
Have you or are you using PUF?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	When received?				
Were you referred by FSCD?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, what is the name of your worker?				
If not FSCD, who were you referred by?							
Previous Clinicians and Therapists?							
Current Clinicians working with child?							
PREFERRED THERAPY SCHEDULE							
Please circle the days and times that best suit your schedule.	Preferred Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	Preferred Time of Day	MORNINGS	9 - 12	AFTERNOONS	12 - 3	LATE AFTERNOON	3 - 6
OBSERVATIONS YOU WOULD LIKE TO SHARE							
i.e. Behaviour, Communication & Socialization Skills, Cognitive Abilities, Physical & Motor Development, Self-Help & Adaptive Functioning							
Parent Priorities?							
Other special requests?							