CASE HISTORY

Student's Name _____ Date _____

Person(s) Reporting: _____ Relation to Child _____

- Who referred you? _____
- Please check all the concerns that apply regarding your child:

❑ Conduct	❑ Learning
❑ Discipline	❑ School performance
❑ Aggressive behavior	❑ Motivation
❑ Hyperactivity	❑ Problems with teachers
❑ Temper tantrums	❑ Problems with peers
❑ Depression	❑ Distractibility/attention
❑ Anxiety	❑ Academics (specify: _____)
❑ Impulse control	❑ Interpreting social cues
❑ Panic attacks	❑ Organization
❑ Phobias	❑ Alcohol and/or substance abuse
❑ Self esteem	❑ Speech or language
❑ Identity concern	❑ Family communication
❑ Witness to violence	❑ Death or major illness in family
❑ Bedwetting/soiling	❑ Adjusting to divorce/separation
❑ Appetite disturbance	❑ Parental stress
❑ Sleep disturbance	❑ Single-parenting
❑ Tics or unusual mannerisms	❑ Step-parenting

- When was a problem first noted? _____

ADDITIONAL COMMENTS ARE WELCOME:

BIRTH HISTORY

- Is the child adopted? _____ Age at adoption: _____ Comments: _____

Were there any difficulties, maternal illnesses, accidents, etc. during pregnancy? _____

- Delivery:
  Length of pregnancy _____ Length of labor _____hours Birth weight _____
  Labor spontaneous____ or induced____(If induced, explain) _____
  Type of anesthetics _____
  Forceps (explain) _____
  Cesarean Section (explain) _____
  Baby bluish or yellowish after birth (explain) _____
  Breech birth (explain) _____
  Incubator (explain) _____
  Anoxia (explain) _____

- Comments concerning prenatal and birth history: _____

HEALTH HISTORY

- List the child's illnesses, operations, and/or hospitalizations:

	Age at Onset	Duration	Description (continue on back if necessary)
Allergies			
Ear infections			
Frequent colds			
Other illness			
Accidents			
Surgery			
Hospitalizations			
Physical disabilities			
Other:			

- Current medications:

Medication	Dose	Frequency	Date started	Treatment for:

DEVELOPMENTAL HISTORY

As best you can recall, at what age did the following occur?

Sat alone _____ Crawled _____

Walked alone _____ Drank from a glass _____

Began to draw _____ Rode a two-wheeler _____

Used single words: _____ Used two words together _____

Used sentences of three or more words: _____

Comments about your child's language or motor development: _____

_____

_____

_____

Describe any balance or coordination problems: _____

_____

_____

Does child prefer right or left hand? _____

Which hand do family members prefer? _____

Does anyone in the immediate or extended family (siblings, parents, grandparents, aunts, uncles, cousins) have speech/hearing/other medical problems/learning problems? If yes, briefly describe: _____

_____

_____

_____

_____

SIBLINGS:

Name	Age	Grade	School Attended	School Performance/Comments

EDUCATIONAL HISTORY

- Schools attended:

Date	Grade(s)	School	Address/Location

- Present school progress (Describe <u>specific</u> problems your child is experiencing.):

_____

_____

_____

_____

- List the goals you would most like to see attained through tutoring and then number them to rank their priority.

Goal:	Priority rank:

SOCIAL HISTORY

(Please describe as fully as possible. Use the other side if needed.)

How does the student interact with: Adults? _____

Siblings? _____

Other children? _____

What solitary activities does the student choose? _____

What activities hold the student's interest the longest? _____

_____

Does the student have hobbies? _____

Are there pets in the home? _____

Does the student have responsibilities at home? If so, please detail: _____

_____

Describe the student's sleeping and eating habits: _____

_____

List the ways in which your child makes his/her wants known: _____

_____

With whom does the child live? _____

Is the primary care giver employed outside the home? _____

If so, who cares for child? (sitter, grandparent, etc.): _____

Other individuals living in the home (e.g. grandparents, housekeeper, etc.): _____

_____

IF PARENTS ARE DIVORCED, PLEASE ANSWER THE FOLLOWING:

Who has custody of the child? _____

How often does the child see the non-custodial parent? _____

If custody is shared, please describe: _____

_____

_____

Are there step-parents? _____

Are there half- or step-siblings? (names, ages, and in which home): _____

_____

_____

ADDITIONAL COMMENTS: (Use the other side.)

CONSENT TO SHARE INFORMATION

Student's Name_____ Today's Date _____

In order to improve the quality of and inform the service provided to the student, I/we authorize Maria Fagan Hassani to release information to and obtain information from

- ☐ all professionals involved in the student's care (doctors, therapists, teachers, etc.).

OR

- ☐ _____ (fill in names(s)) **only.**

I/We ask that you share information (check any that apply)

- ☐ of any nature as necessary for my child's services.
- ☐ of the following nature(s) only:
  - ☐ medical
  - ☐ psychological
  - ☐ educational
  - ☐ other _____
- ☐ only after verbal or written notification.

_____ _____

Printed name of parent or guardian Signature of parent or guardian

_____ _____

Printed name of parent or guardian Signature of parent or guardian

Maria Fagan Hassani, M.A., ET/P
Educational Therapist
818-538-4370
maria@learninglink.me
www.learninglink.me

GENERAL INFORMATION

Date_____ Person Reporting_____

STUDENT'S NAME_____ Birthdate: _____Age:_____ Grade:_____

Parents/Guardians:

MOTHER_____ Home phone (___)_____ Work phone (___)_____ Work hours_____

Address _____ Zip _____

Occupation: _____Highest level of educ. _____ Primary Language:_____

Employer: _____ Secondary Language:_____

Address:_____ Custody days if separated: _____

FATHER_____ Home phone (___)_____ Work phone (___)_____ Work hours_____

Address _____ Zip _____

Occupation: _____Highest level of educ. _____ Primary Language:_____

Employer: _____ Secondary Language:_____

Address:_____ Custody days if separated: _____

BILLING PARTY: _____**E-mail** _____

EMERGENCY CONTACT: **Phone:**

AFTER SCHOOL CAREGIVER: Name:_____ Phone: _____

SCHOOL:_____ Phone: _____

Address:_____ City: _____ Zip:_____

Teacher/Advisor:_____ Phone (if different) _____

Other Relevant School Staff	Subject/Service	Phone (if different)
1._____	_____	_____
2._____	_____	_____

EVALUATION/TESTING: (Please use back if more space desired.)

1. Type (educational/psychological/neurological/etc.):_____Date:_____

   Agency:_____Examiner:_____Phone: _____

   Address:_____Zip _____

2. Type (educational/psychological/neurological/etc.):_____Date:_____

   Agency:_____Examiner:_____Phone: _____

   Address:_____Zip _____

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OTHER SERVICES (psychotherapy, speech/language, tutoring, OT, PT, etc.)

NAME: _____Phone:_____

Address: _____

Service provided:_____From (date)_____To (date)_____Current? Y/N

NAME: _____Phone:_____

Address:_____

Service provided:_____From (date)_____To (date)_____Current? Y/N

MEDICAL INFORMATION

CURRENT MEDICAL CONDITIONS (e.g. epilepsy, asthma, severe allergies, other chronic illness): _____

_____

REGULAR MEDICATIONS (type, frequency, side effects):_____

_____

VISION: Glasses? _____ Most Recent Eye Exam (date/results): _____

HEARING: Hearing Aid? _____ Most Recent Hearing Exam (date/results):_____

Comments: _____

Pediatrician: _____Phone: _____

Address:_____

Maria Fagan Hassani, M.A., ET/P
Educational Therapist
818-538-4370
maria@learninglink.me
www.learninglink.me

CANCELLATION POLICY

Dear Clients,

Consistency is the key to making progress and solidifying skills. Missed sessions reduces my ability to help your child. When you receive my invoice the last week of the month for the following month, please look over dates carefully for conflicts. Let me know immediately if I need to adjust the invoice dates. This is the time to solidify sessions for the following month. Once we have agreed on sessions for the month, any missed sessions will be made up within two months. I always allow ten days to receive payments. If we are scheduled for the month, but you need to cancel giving 24 hours or more notice, we will make up the session at a mutually agreed time within 2 months. If I have to cancel for any reason, you will have the option of making up or a credit. Late cancels are subject to my availability.

Please note the following:

***As usual 24 hour cancellation is required to receive a make-up session.**

***Make-ups will be done on mutually agreed time within two months. Sessions will not be rolled over to the next month except in unusual circumstances**

***If I have to cancel for any reason you have the choice of a make-up or a credit**

***If less than 24 hours is given it is then considered a late cancel and make-ups are up to my discretion.**

***Make-ups for late cancels will be given only if it is something like last minute sickness or emergency, and I can accommodate it.**

***When you are considering terminating your sessions with me, I would appreciate 1 month notice.**

I know everyone's lives are beyond hectic and some things are unavoidable, but every effort needs to be made to think ahead and reduce late cancels. I will always understand but may not be able to accommodate you in a make-up.
I am looking forward to working with your child!

Wendy Lamoreaux, MEd., ET/P
AET Educational Therapist

SCHOLARSHIP REQUEST (Valid for 90 days after start of services.)

Date:_____

Parent(s) Name: _____

Student Name: _____

Number of sessions per week you'd like to provide for your child: _____

50 minute Educational Therapy sessions are $175, how much are you able to pay for each session? _____

1) What is the reason(s) for your request? Please be as specific as possible.

_____

_____

_____

_____

_____

2) Scholarship requests are reviewed every three months. Do you foresee the reasons for your request changing in the next 90 days? Yes or No? Please explain.

_____

_____

_____

_____

3) Are you willing to schedule sessions to be held in my office in lieu of me traveling to your child's school? Yes or No (Please circle one.)

4)Why do you think your child and/or family are good candidates for this scholarship?

_____

_____

_____

_____

_____

_____

_____

(Please use the back of this page if necessary.)