SOCIAL SKILLS GROUP
INTAKE QUESTIONNAIRE

DEMOGRAPHIC/ CURRENT INFORMATION

FULL NAME:_____ **NICKNAME:**_____

AGE:_____ **DOB:**_____/_____/_____ **GENDER:**_____

RACE:_____ **ETHNICITY:**_____ **NATIONALITY:** _____

RELIGION:_____

ADDRESS: _____

BILLING ADDRESS:_____

MOTHER/ GUARDIAN:_____ **OCCUPATION:**_____

CELL PHONE:_____ **HOME PHONE:**_____

EMAIL:
_____

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FATHER/ GUARDIAN:_____ OCCUPATION:_____

CELL PHONE:_____ HOME PHONE:_____

EMAIL:
_____

HOUSEHOLD INFORMATION

HOUSEHOLD SIZE:_____ MONTHS/ YEARS AT ADDRESS:_____

WHO LIVES IN THE HOUSEHOLD:_____

AGES OF SIBLINGS LIVING IN THE HOUSEHOLD: _____

EMERGENCY CONTACTS

EMERGENCY CONTACT NAME:_____

RELATIONSHIP:_____ CELL PHONE:_____

HOME PHONE:_____ WORK PHONE:_____

ADDRESS:_____

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EMERGENCY CONTACT NAME:_____

RELATIONSHIP:_____ **CELL PHONE:**_____

HOME PHONE:_____ **WORK PHONE:**_____

ADDRESS:_____

EMERGENCY CONTACT NAME:_____

RELATIONSHIP:_____ **CELL PHONE:**_____

HOME PHONE:_____ **WORK PHONE:**_____

ADDRESS:_____

HEALTH INSURANCE/ COVERAGE

PRIMARY INSURANCE:_____

PRIMARY INSURANCE TELEPHONE NUMBER:_____

POLICY/ ID:_____ **GROUP NO:**_____

POLICYHOLDER NAME:_____ **DOB:**_____

POLICYHOLDER'S RELATIONSHIP:_____

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SECONDARY INSURANCE:_____

SECONDARY INSURANCE TELEPHONE NUMBER:_____

POLICY/ ID:_____ **GROUP NO:**_____

POLICYHOLDER NAME:_____ **DOB:**_____

POLICYHOLDER'S RELATIONSHIP:_____

FINANCIAL INFORMATION FOR ASSISTANCE

ARE YOU APPLYING FOR A SCHOLARSHIP: YES _____ NO _____ IF NO, SKIP SECTION
(SCHOLARSHIPS ARE AVAILABLE TO INDIVIDUALS/ FAMILIES WITH LIMITED RESOURCES)

TOTAL GROSS ANNUAL HOUSEHOLD INCOME:_____

OTHER ASSISTANCE YOU RECEIVE

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP): YES_____ NO____

CASH ASSISTANCE: YES_____ NO_____

SUPPLEMENTAL SECURITY INCOME: YES_____ NO_____

MEDICAID: YES__ NO__ MEDICAID WAIVER YES__ NO__ SELF-DIRECTION YES__ NO__

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OTHER: YES_____ NO_____
(IF YES PLEASE SPECIFY BELOW)

_____

_____

PLEASE SHARE WITH US YOUR NEED FOR FINANCIAL ASSISTANCE:

_____

_____

_____

_____

_____

_____

I HEREBY CERTIFY THAT THE FINANCIAL INFORMATION FOR FINANCIAL ASSISTANCE ABOVE IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IN THE EVENT OF MY INFORMATION BEING FALSE OR INCORRECT AT ANY STAGE, MY FINANCIAL ASSISTANCE OR PARTICIPATION IN THE PROGRAM SHALL BE LIABLE TO CANCELLATION OR TERMINATION WITHOUT NOTICE.

SIGNATURE_____

PRINT NAME_____ DATE_____

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GENERAL HEALTH INFORMATION

MEDICAL DIAGNOSIS/ CHRONIC ILLNESS? YES_____ NO_____

_____

_____

_____

_____

SLEEP PATTERNS (E.G. BEDTIME, HOURS OF SLEEP, NIGHTTIME AWAKENING, ETC.)

_____

_____

_____

DIETARY/ EATING HABITS

_____

_____

_____

_____

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DIETARY RESTRICTIONS/ SPECIAL DIET? YES_____ NO_____

_____

_____

_____

_____

ALLERGIES (INCLUDING ALLERGIES TO FOOD/ MEDICATION) YES_____ NO_____

IF YES, PLEASE SPECIFY_____

_____

HISTORY OF ANAPHYLAXIS? YES_____ NO_____ EPI-PEN? YES_____ NO_____

PHYSICAL LIMITATIONS? YES_____ NO_____

IF YES, PLEASE SPECIFY_____

_____

_____

STUDENT/ EMPLOYMENT STATUS AND VOLUNTEER INFORMATION

ARE YOU A STUDENT? YES_____ NO_____

FULL-TIME_____ PART TIME_____ IEP/ 504 PLAN? YES_____ NO_____

SOCIAL SKILLS GROUP
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ARE YOU EMPLOYED: YES_____ NO_____

FULL-TIME_____ PART-TIME_____

ARE YOU VOLUNTEERING: YES_____ NO_____

FULL-TIME_____ PART-TIME_____

SCHOOL/ EMPLOYER/ ORGANIZATION NAME, ADDRESS AND TELEPHONE NUMBER

_____

_____

_____

OTHER PROGRAMS (E.G. DAY PROGRAMS, DAY HAB, VOCATIONAL TRAINING, ETC.)

PROGRAM NAME, ADDRESS AND TELEPHONE NUMBER

_____

_____

_____

FINE MOTOR SKILLS/ GROSS MOTOR SKILLS

HAND PREFERENCE_____

SOCIAL SKILLS GROUP
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VISUAL PERCEPTION/ VISUAL MOTOR_____

GRASP_____

WRITING_____

BALANCE/ COORDINATION_____

SOCIAL SKILLS/ LANGUAGE

INITIATING INTERACTIONS_____

MAINTAINING INTERACTIONS_____

RESPONSE TO GROUP SETTINGS_____

FOLLOWING DIRECTIONS_____

PROBLEM SOLVING/ NEGOTIATION_____

SHARING/ TURN TAKING_____

SPORTSMANSHIP_____

COMMUNICATION_____

BEHAVIOR

UNUSUAL BEHAVIOR/ BEHAVIOR PROBLEMS? YES_____ NO_____

SOCIAL SKILLS GROUP
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IF YES, PLEASE SPECIFY_____

_____

_____

_____

TRIGGERS/ REASONS FOR THE BEHAVIOR?_____

_____

_____

_____

SENSORY PROCESSING
(OVER RESPONSIVE OR UNDER RESPONSIVE TO STIMULI/ INPUT)

VISUAL_____

TOUCH_____

SMELL_____

TASTE_____

SOUND_____

SOCIAL SKILLS GROUP
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ACTIVITIES OF DAILY LIVING SKILLS (ADLs)

(IF NOT APPLICABLE DUE TO AGE PLEASE SKIP)

FEEDING/ TOILETING_____

_____

GROOMING/ HYGEINE_____

_____

DRESSING/ UNDRESSING_____

_____

MONEY_____

_____

FOOD PREP/ COOKING_____

_____

TRAVEL/ NAVAGATION_____

_____

CLEANING/ CHORES_____

_____

LAUNDRY_____

_____

SOCIAL SKILLS GROUP
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SAFETY SKILLS
(IF NOT APPLICABLE DUE TO AGE PLEASE SKIP)

KNOWLEDGEABLE OF ADDRESS/ TELEPHONE NUMBER_____

_____

KNOWLEDGEABLE OF EMERGENCY CONTACTS _____

_____

IDENTIFYING SIGNS_____

_____

CROSSING THE STREET _____

_____

IDENTIFYING DANGER/ HAZARDS_____

_____

BODY SAFETY _____

_____

ASKING FOR HELP/ SELF-ADVOCACY_____

_____

SOCIAL SKILLS GROUP
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FIRE SAFETY/ EMERGENCY PREPAREDNESS _____

_____

ALL ABOUT YOU/ YOUR CHILD

TALENTS/ STRENGTHS/ SKILLS_____

_____

_____

_____

_____

_____

HOBBIES/ INTERESTS_____

_____

_____

_____

PEOPLE/ THINGS THAT MAKE ME HAPPY_____

_____

_____

SOCIAL SKILLS GROUP
INTAKE QUESTIONNAIRE

_____

PEREFERENCES_____

_____

_____

_____

FAVORITE COLORS_____

FAVORITE FOODS_____

FAVORITE SHOWS_____

FAVORITE MOVIES_____

FAVORITE TOYS/ BELONGINGS_____

FAVORITE VIDEO GAMES_____

FAVORITE CHARACTERS_____

MUSIC GENRES/ ARTISTS_____

FAVORITE SCHOOL SUBJECT_____

OTHER FAVORITES_____

SOCIAL SKILLS GROUP
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GOALS, CONCERNS AND COMMENTS INCLUDING SPECIAL CIRCUMSTANCES:

(SPECIAL CIRCUMSTANCES MAY INCLUDE VICTIMS OF ABUSE/ CRIME, HOMELENESS, ETC.)

_____

_____

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_____

_____

SOCIAL SKILLS GROUP
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APPLICABLE DOCUMENTATION REQUESTED
(CHECK OFF ATTACHED DOCUMENTATION, MUST BE CURRENT OR MOST RECENT)

____ HEALTH EXAMINATION FORM/ ANNUAL PHYSICAL

____ DENTAL HEALTH FORM

____ PSYCHOSOCIAL EVALUATION

____ PSYCHOLOGICAL EVALUATION

____ OTHER EVALUATIONS (E.G. PSYCHOSEXUAL, SPEECH, ETC.)

____ IEP/ 504 PLAN

____ LIFE PLAN

____ DDP2/ CAS ASSESSMENT

____ LOC

____ NOD