HOPE Reach
A program of Project HOPE Foundation

Intake Form

General Information

Name of Child: ______________________ **Date of Birth:** ______________________

O Male O Female Current Age: ______________________

Primary Address: ______________________ Secondary Address: ______________________
______________________ (if any) ______________________
______________________ ______________________

Current Diagnosis: ______________________ Date of Diagnosis: ______________________
Diagnosed by: ______________________ Age at Diagnosis: ______________________
Affiliation: ______________________ Referred to HR by: ______________________

PARENTS AND/OR GUARDIANS

Mother's Name: ______________________ **Father's Name:** ______________________
Social Security #: ______________________ Social Security #: ______________________
Occupation: ______________________ Occupation: ______________________
Employer Name: ______________________ Employer Name: ______________________
Home Phone: ______________________ Home Phone: ______________________
Mobile Phone: ______________________ Mobile Phone: ______________________
Work Phone: ______________________ Work Phone: ______________________
Best Number Home Mobile Work Best Number: Home Mobile Work

Email Address: ______________________ Email Address: ______________________

Are parents: _____married _____divorced
_____ separated?
Who completed questionnaire? ______________________

If divorced, custodial parent: ______________________
Primary language spoken at home: ______________________

SIBLINGS

Sibling Name: ______________________ Date of Birth: ______________________
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SCHOOL, BABYNET, AND DDSN INFORMATION

School District: ______________________

School Name: ______________________

Principal/ Director: ______________________

Teacher(s): ______________________

School Phone: ______________________

School Address: ______________________

____

Medicaid Number: ______________________

Service Coordinator: ______________________

Svc Coord. Phone: ______________________

BabyNet Coordinator: ______________________

BabyNet Coord. Phone: ______________________

Typically, clients who are in school for the full day receive 10-15 hours of therapy per week. Clients who are not in school typically receive 30 hours per week.

Please complete the schedule to indicate times of day that your child **is available** beginning in 4 weeks (i.e. when would you like therapy sessions to take place?).

Mon	Tues	Wed	Thur	Fri	Sat	Sun

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