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EDUCATION INTAKE QUESTIONNAIRE

Parent Information

Mother's Name _____ Father's Name _____

Mother's Address _____

Father's Address (if different than above) _____

Mother's Phone Numbers (Home) _____ Work _____ Cell _____

Father's Phone Numbers (Home) _____ Work _____ Cell _____

Mother's E-mail _____ Father's E-mail _____

Emergency Contact _____ Relationship _____

Address and Phone Number _____

General Student Information

Name _____ Age _____ Gender _____ Birthday _____

Address _____ Resides with _____

Name of School _____

School Address _____

School Phone _____ Student's Teacher _____

Grade _____ Contact Information for Student's Teacher _____

Does the Student have an IEP? Yes No If yes, what is the disability? _____

Name of School Corporation _____ Phone Number _____

School Corporation Address _____

List all siblings (whether or not living in the home)

Student Educational Information

List all schools attended and dates attended.

Name of School	Dates Attended

List the current subjects the student is being taught, the teacher's name, and the student's current grade in that subject.

Subject	Teacher's Name	Grade

What do you consider your child's academic strengths to be?

What do you consider your child's social strengths to be?

In which areas would you like to see your child academically improve?

In which areas would you like to see your child socially improve?
Intake Questionnaire

How do you think your child's school can help your child succeed?

Social History

Does your child:

make friends easily?	Yes	No	keep friendships?	Yes	No
prefer playing with younger students?	Yes	No	prefer the company of adults?	Yes	No
prefer to play alone?	Yes	No	have social acceptance by classmates?	Yes	No
Are there any other children in your neighborhood with whom your child plays?				Yes	No

List extracurricular activities in which your child is involved.

What does your child enjoy doing during free time?

Check all that apply regarding your child's temperament.

- Has a short attention span
- Has temper tantrums
- Is shy or timid
- Does not get along well with siblings
- Overreacts when not getting own way
- Seems uncomfortable meeting new people
- Easily frustrated
- Gives up easily
- Is impulsive
- Often seems sad or unhappy
- Has a lot of fear

Has your child ever been arrested? Yes No If yes, explain.

Has your child experienced the loss of a significant person through death, abandonment, or incarceration?

Yes No If yes, explain. _____

Does your child receive counseling or therapy? Yes No Counselor's Name _____

Discipline Information

Describe your child's behavior at home.

Describe what you know about your child's behavior at school.

On any given week how many office referrals does your child receive? _____

Describe your child's suspensions for the past two years.

Suspension Date	Reason	Number of Days

In the past two years, have you had to pick up your child early or keep your child at home at the request of school officials because of your child's behavior? Yes No If yes, explain.

Has a Functional Behavior Assessment been conducted for your child? Yes No

Does your child have a Behavior Intervention Plan? Yes No

Special Education/ 504

Has your child ever been evaluated by the school to determine eligibility for special education or a Section 504 Plan? Yes No

If yes, when? _____

Have you had you ever had a private educational evaluation of your child? Yes No

If yes, list all the private evaluations done for your child, by whom, and when they were conducted.

Date	Type of Evaluation	Provider

If your child is currently eligible for special education (has an IEP), when was your child found eligible?

Related Services

As a result of your child's IEP, does your child receive any of the following:

- Audiology
- Interpreting Services
- Occupational Therapy
- Parent Counseling and Training
- Psychological Services
- Rehabilitation Counseling
- Social Work Services
- Transportation
- Counseling Services
- Medical Services
- Orientation and Mobility Services
- Physical Therapy
- Recreation
- School Health/Nurse Services
- Speech and Language Services

List any additional concerns or other information that you would like for me to know.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(In compliance with HIPAA Reg. § 45 CFR 164.508)

TO: _____

You are hereby authorized to release the protected health information in your possession concerning me, or the person whose representative I am, to:

NAME Alexandra M. Curlin, Attorney at Law
ADDRESS The Curlin Law Office
One College Park
8910 Purdue Rd, Ste 480
Indianapolis, IN 46228
Phone (317) 616-3994
Fax (317) 536-3663

- Copies of all charts, records, correspondence, physicians' orders, progress notes, nurses' notes, medication records, therapy notes, laboratory reports, x-ray reports, consents, operative notes, pathology reports, anesthesia reports, admission and discharge summaries and any other medical information.
- Copies of all itemized statements, bills, payment receipts or other financial records.
- A report to my attorneys concerning my medical treatment, condition or prognosis.
- Copies of all mental health records.
- Other: _____

This authorization is initiated "at the request of the individual." You are authorized to discuss with my attorneys all matters concerning my medical treatment, condition, prognosis and the records which are being requested. Please do not discuss or disclose information to any person(s) other than my attorney without written authorization from me. A photocopy of this authorization shall be deemed the same as one bearing my original signature.

I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. (β 45 CFR 164.508(c)(2)(3)a

I understand that I may revoke this authorization by notifying, in writing, you and Alexandra M. Curlin of my desire to revoke it. However, I understand that if I revoke this authorization it will not have any effect on actions taken by any covered entity that relies on it before I revoke it. (β 45 CFR 164.508)

I understand this authorization will expire on the happening of the following event that relates to me or the purpose of the use for disclosure: Upon receipt of my protected health information by Alexandra M. Curlin, Attorney at Law.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization.

Signature of Individual or Representative

Printed Name

Date

Description of representative's authority to act for the individual (if applicable):

Patient's Name _____ Patient's Address _____

Patient's SSN _____ Patient's DOB _____

This form must be completed before signing.