Fort Wayne Center for Learning
Client Information

Date _____

Referred By _____ Title/Position _____

IDENTIFYING INFORMATION

Full Name				Goes By	
Birth date		Age		Grade	
Address					
City, State, Zip				County	

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian		Relationship	
Address			
Place of Business		Work Phone	
Occupation		Home Phone	
Email Address		Cell Phone	
Parent/Guardian		Relationship	
Address			
Place of Business		Work Phone	
Occupation		Home Phone	
Email Address		Cell Phone	

ALTERNATE CONTACT

Contact		Relationship	
Address			
		Work Phone	
		Home Phone	
		Cell Phone	

RACIAL BACKGROUND

We encourage you to <u>voluntarily</u> provide the following information on racial background and ethnicity. Demographic information is often requested by our funders.
The child's racial background: (check all that apply) □ American Indian or Alaskan Native □ Asian □ Black or African American □ Hawaiian or Pacific Islander □ White □ Other/Multiracial (specify racial background _____)
The child's ethnic background: (check one) □ Hispanic or Latina □ Not Hispanic or Latina

FAMILY HISTORY

Number of Brothers		Number of Sisters		Position (oldest, youngest)	
History of learning difficulties within the family. (Please elaborate.)					

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BIRTH HISTORY

Unusual factors regarding pregnancy and/or birth? (Please elaborate.)	

PHYSICAL AND DEVELOPMENTAL DATA

Age of sitting		Walking		1st Words		1st Sentences	

Right-handed or left-handed	
Describe any hand-eye coordination/visual-motor difficulties:	
Describe any vision or hearing difficulties:	
Describe any attention difficulties:	
Describe any medical conditions and/or diagnoses (including significant medical events during childhood – high fevers, unusual illness, accidents, etc.)	
Medication history:	
Known allergies:	
Present sleeping habits	
Present energy/activity level	

SOCIAL AND PERSONAL FACTORS

Relationship with parents and siblings	
General home attitude	
Relationship with friends	
Attitude toward school	
Attitude toward learning problems	

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EDUCATIONAL HISTORY

Current school		Teacher	
Address		Phone	
School District			
Special programs/services provided (include start/end dates and # of hours/week			
Teacher's Reports			
Grades repeated and why:			
Describe any changes of schools and/or teachers			

OTHER THERAPIES CHILD IS RECEIVING

Please check what other services/therapies your child is currently receiving:

- ☐ **Speech** **Providers name: _____**
- ☐ **Physical Therapy** **Providers name: _____**
- ☐ **Occupational Therapy** **Providers name:_____**
- ☐ **Anger Management** **Providers name:_____**
- ☐ **Counseling/Therapy** **Providers name:_____**
- ☐ **Other** **Providers name:_____**

OTHER ASSESSMENTS

Outside Assessment(s)			
Type/Name	Tested by/title	Date	Results/Recommendations

ADDITIONAL COMMENTS

Please add any other information that may be relevant. Use the back if necessary.

Turn page over and write any additional information on back