Community Program for Exceptional Children

Intake Form

The following information will be held strictly confidential

Name: _____ DOB: _____

Address: _____

_____

Parent1/ Name: _____

Mobile Phone: _____ Email: _____

Occupations/ Employer: _____

Parent 2/ Name: _____

Mobile Phone: _____ Email: _____

Home Phone: _____

Occupations/ Employer: _____

Languages spoken at home: _____

Referred by: _____

What are your child's diagnosis and challenges?

What can your child do [e.g. gross and fine motor skills, speech, social skills,]

What do you hope to see next in your child's development?

Please describe any illness, accident, or muscular/skeletal problem and pain that has required medical attention?

Please check any of the following that apply to your child:

___ Allergies/Asthma/Sinus
___ Bone Joint Disease
___ Cardiovascular/Heart
___ Chronic Pain
___ Diabetes
___ Digestive
___ Dizziness
___ Headaches
___ High/Low Blood RR
___ Respiratory/Lungs
___ Scoliosis
___ Seizures
___ Constipation
___ Skin Disorders
___ Vision
___ Other medical conditions (please specify on the backside of this page)

Please initial the following and sign below

_____ I understand that the lessons given by the ABM/NeuroMovement Practitioner, (hereafter the"Practitioner") are a way to open doors to new possibilities of movement and development, and are educational only. They are not medical and do not take the place of appropriate medical care.

_____ I agree to let the Practitioner know immediately if I see my child experiencing any discomfort.

_____ I affirm that I have notified the Practitioner of all known medical conditions and injuries of my child and will inform him/her of any changes in my child's health and medical condition.

_____ I understand that I am responsible to cancel my child's lessons at least 24 hours in advance, unless there is an emergency. If I fail to do so, my child may not qualify to receive lessons at COPEC in the future.

_____ _____
Signature Parent 1 Date

_____ _____
Signature Parent 2 Date