Empowering Steps
Intake for Initial Assessment

CLIENT'S (CHILD) NAME _____ **Today's Date:**_____

D.O.B _____ **MALE** ◯ **FEMALE** ◯
MM DD YYYY

PARENT/GUARDIAN NAMES _____

PHONE # _____ **CELL PHONE #** _____

EMAIL ADDRESS _____ **Language spoken at home:** _____

DIAGNOSIS(ES):_____

OTHER RELEVANT PAST MEDICAL HISTORY:

_____

MEDICATION YES ◯ **NO** ◯ If yes, please list.

_____

Verbal ◯ **/ Non Verbal** ◯ **Walking** ◯ **/Non Walking** ◯ **Vision Impairments** ☐

Hearing Impairments ☐ **How did you hear about us?** _____

WHAT ARE SOME AREAS OF CONCERN? (ex: sensory processing, behaviour, or mobility issues)

_____

OTHER ONGOING THERAPIES: _____

(Optional) Additional Reports Completed by Professionals - Please bring to assessment.

WHO WILL BE DROPPING OFF: To assessment?_____ **To sessions?**_____

FUNDING AVAILABILITY: MCFD_____ **Private**_____ **Other** _____

WHICH THERAPIES ARE YOU INTERESTED IN?

Behaviour Intervention ☐ **Movement Therapy** ☐ **Music Therapy** ☐

Speech-integrated ES ☐ **Physio-integrated ES** ☐ **Social Groups** ☐

Client Availability for Assessment:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

THERAPIST(s) _____ ☐ **Confirmed**

DAY & TIME OF ASSESSMENT _____ ☐ **Confirmed**