



*A Division of Rehab Resources, Inc.*

## **EDUCATIONAL BACKGROUND:**

<b>Related Question</b>	<b>COMMENTS (examples)</b>
1. Does your child attend school? Where?	
2. What grade is he/she in now?	
3. Does your child receive special education or therapies in school? (PT/OT/Speech)	Please list frequency, length of session, and if individual or group:
4. May we communicate with school staff?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please complete consent form at time of evaluation.
5. Does your child have an IEP?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please bring a copy of your child's current IEP to evaluation. This will help us provide treatment without duplication of services.
6. What are the differences you are seeking between school therapy and community based services?	
7. What type of home carryover is being provided to meet goals?	
8. Is school able to monitor and change home carryover activities?	

**\*Submitting this information at least 2 days prior to the initial appointment will provide the therapist opportunity to review the information in order to perform a more thorough evaluation.**