Family Achievement Center, Inc.

8320 City Centre Drive, Suite G
Woodbury, MN 55125
Phone: 651-738-9888
Fax: 651-738-9889

Social Skills Group Parent/Guardian Intake Form

Print and return this form to FAC.

CONTACT INFORMATION

Child's Name: _____

Date: _____

Father: _____ Mother: _____

Home Phone Number: _____ Cell: _____

Address:

_____

Email: _____ Referred by:_____

CHILD'S INFORMATION

Age:_____ DOB:_____

Diagnosis (if any):_____

School:_____ Regular Ed:_____Special Ed:_____

Grade Level: _____ Aide: (circle) Y/N _____ % (of day)

Current or Recent Speech Language Pathology (SLP) services:

Therapist & frequency: _____

Goals:_____

_____

Current or Recent Occupational Therapy services:

Therapist & frequency_____

Goals: _____

_____

Behavioral Services (i.e. psychologist, social worker, etc):

Therapist & frequency: _____

Goals: _____

Can we contact your child's SLP to communicate the group's goals and inquire about your child's social skills within their setting? _____

Therapist name and phone number:_____

COMMUNICATION LEVELS

At what level does your child communicate (check) Words_____ phrases_____ sentences_____ conversation_____

(Please rate: good, fair, poor) Eye contact_____ Greetings _____

SOCIAL SITUATION QUESTIONS

Can your child handle a group setting (4-6 kids) with 2 therapists and structured lessons?

_____

Can your child do table top activities for 10 minutes? Y/N **20 minutes?** Y/N **30+ minutes?** Y/N

Please list strengths and weaknesses your child has in the area of social skills.

Strengths: _____

_____

_____

Weaknesses: _____

_____

_____

Please list three goals you have for your child in the area of social skills.

1. _____

_____

2. _____

_____

3. _____

_____

What are some of your child's interests/activities within and out of school?

_____

_____

_____

_____

Are there any situations, relevant to our group, which may upset or agitate your child?

_____

_____

_____

_____

Does your child perseverate on any objects, topics, or activities? Please list.

_____

_____

Is your child on a specific diet? If yes, please explain.

_____

_____

_____

Does your child have any allergies (food or otherwise) or other medical conditions we need to be aware of?

_____

_____

Please add any additional comments and/or information regarding your child, which you feel would be relevant to our social skills therapy group.

_____

_____

_____

_____

_____

_____

Parent Checklist

Rank the top *five* (1 being the most important) social skills that need to be addressed.

_____ Listening Skills
_____ Greeting Others
_____ Eye Contact
_____ Initiating a Conversation
_____ Making Supportive Comments
_____ Making Comments in Conversation
_____ Keeping Comments Brief
_____ Asking Questions
_____ Answering Questions
_____ Asking for Help
_____ Using Appropriate Vocal tone/volume
_____ Identifying Facial Expressions
_____ Using Appropriate Body Language
_____ Identifying Appropriate Body Language
_____ Other (please specify): _____

_____ Participating in Groups
_____ Compromising
_____ Negotiating
_____ Identifying Problems
_____ Proximity/ Personal Space
_____ Apologizing
_____ Identifying Emotions
_____ Identifying Consequences
_____ Imaginative Play
_____ Conversational Turn-Taking
_____ Asking Questions about Others
_____ Exhibiting Appropriate Facial Expressions
_____ Joining in with Peers

Please print out and return this questionnaire to Family Achievement Center prior to the first group session:

Family Achievement Center
Attn: Susan Hoel
8329 City Centre Drive
Woodbury, MN 55125
You may also fax this information to 651-738-9889

_____ _____

Parent or Guardian Signature Date

Family Achievement Center Group
Permission Form

Authorization for Video, Audio, Recording, and Photo of Patient Group/Treatment

Name:_____ DOB:_____

By signing and dating this permission form you are acknowledging that:

- Family Achievement Center, Inc. occasionally may conduct a video and/or audio recording of your evaluation, treatment, or group session. These videos are solely used by your therapist, and will remain confidential. Videos and/or audio recordings will not be released for any other purpose without your knowledge or specific consent.

- Family Achievement Center, Inc. has properly notified you that they may use photograph(s) of you, or your child in marketing material for Family Achievement Center, Inc.

- You are giving Family Achievement Center, Inc. consent to use any photograph(s) of you, or your minor child, in marketing material for Family Achievement Center, Inc.

_____ _____

Patient, Parent/Legal Guardian **Date**

_____ _____

Family Achievement Center Representative **Date**

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Providing Services in:
Physical Therapy
Occupational Therapy
Speech/Language Pathology
Aquatic Therapy
Special Therapy Programs

PATIENT REGISTRATION SIGNATURE FORM

PATIENT INFORMATION FAC

PATIENT NAME:_____ DOB:_____
Last First MI

RESPONSIBLE
PARTY NAME:_____
Last First MI

AUTHORIZATIONS and ACKNOWLEDGEMENTS

I have received the Notice of Privacy Practices from Family Achievement Center, Inc.

SIGNATURE: X_____DATE: _____
Parent/Legal Guardian or Self

I hereby authorize FAMILY ACHIEVEMENT CENTER to furnish information concerning my illness and treatments to INSURANCE CARRIERS, PHYSICIANS, THERAPISTS, AND/OR OTHER PERSONNEL, who are involved in taking care of the patient. I authorize payment of any medical benefits to FAMILY ACHIEVEMENT CENTER. **I certify that the information completed on the patient registration form is correct and that I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

SIGNATURE: X_____DATE: _____
Parent/Legal Guardian or Self

----------**MEDICARE PATIENTS** ----------

MEDICARE AUTHORIZATION: I request that payment of authorized medical benefits be made on my behalf to FAMILY ACHIEVEMENT CENTER for services furnished me by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me be released to the HEALTH CARE FINANCING ADMINISTRATION and it's agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

SIGNATURE: X_____DATE: _____
Parent/Legal Guardian or Self

MEDIGAP AUTHORIZATION: I request that payment of authorized Medigap benefits be made on my behalf to FAMILY ACHIEVEMENT CENTER for any services furnished me by this clinic/physician/suppler. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: X_____DATE: _____
Parent/Legal Guardian or Self

HOW DID YOU HEAR ABOUT US? Phonebook ___ Website ___ Friend ___ Dr ___ Other_____

Yes, please include me on the FAC email list:_____
No, I do not wish to receive email announcements:_____
Email address:_____