

CAPERNAUM PEDIATRIC THERAPY, INC.

2018 Self-Regulation Group Intake Form

By completing this form, you are formally registering your child for the **SELF-REGULATION GROUP**.

**Please complete this intake form and mail your payment of \$350 by JUNE 1, 2018 to:
7250 FRANCE AVE S, SUITE 305, EDINA, MN 55435-4313**

Child's Name: _____ DOB: _____

Parents' Names: _____ Email: _____

Address: _____

Phone Number: _____

Emergency Number: _____

Name of person(s) bringing your child to group: _____

Preferred Group Location (please check) ACADEMY OF WHOLE LEARNING CALVIN CHRISTIAN

Pertinent Medical History

Pediatrician: _____

Medical Diagnosis: _____

Medications: _____

Allergies: _____

Special Diet Information: _____

Education

School: _____ Grade: _____

Name and describe services received in school:

Parent Reflections

1. What are your child's strengths? _____

2. What are your child's biggest challenges? _____

3. Does your child have any behavioral concerns? _____

4. What would you like your child to gain from attending this group? _____

5. What do you hope to gain for yourself from this group? _____

6. Is there anything else you would like us to know regarding program planning for your child (e.g., likes, dislikes, behavioral characteristics)? _____

Your child will be assessed at the start of the group and then reassessed at the end. If you have questions regarding the group or group placement, please contact Ali at AlisonB@capernaumpeds.com.

If you have questions regarding payment, please contact Jenny at 952-285-2840.