



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 persevere 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 | _____ Participating in Groups |
| _____ Greeting Others | _____ Compromising |
| _____ Eye Contact | _____ Negotiating |
| _____ Initiating a Conversation | _____ Identifying Problems |
| _____ Making Supportive Comments | _____ Proximity/ Personal Space |
| _____ Making Comments in Conversation | _____ Apologizing |
| _____ Keeping Comments Brief | _____ Identifying Emotions |
| _____ Asking Questions | _____ Identifying Consequences |
| _____ Answering Questions | _____ Imaginative Play |
| _____ Asking for Help | _____ Conversational Turn-Taking |
| _____ Using Appropriate Vocal tone/volume | _____ Asking Questions about Others |
| _____ Identifying Facial Expressions | _____ Exhibiting Appropriate Facial Expressions |
| _____ Using Appropriate Body Language | _____ Joining in with Peers |
| _____ Identifying Appropriate Body Language | |
| _____ Other (please specify): _____ | |

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

1/2010



**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

Family Achievement Center
8320 City Centre Drive, Suite G
Woodbury, MN 55125
Ph: (651) 738-9888
Fax: (651) 738-9889



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: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> Last First MI </div>	
RESPONSIBLE PARTY NAME: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> Last First MI </div>	

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/supplier. 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: _____