Special Needs Ministry Intake Form

Please Tell Us About Your Child

Thank you for connecting with the Treasured Arrows Special Needs Ministry at Faith Community Church! The information on this questionnaire is strictly for our Team Staff and Volunteers to access in order to provide the best care and experience for your child. This information will be kept confidential and is intended to help our team understand the needs of your child so that we can provide cognitively appropriate accommodations to help your child feel more comfortable upon entering this environment. **Please fill out to your level of comfort in sharing.**

Child's First and Last Name

- **First Name_____**
- **Last Name_____**
- **Child's Nickname_____**
- **Child's Birthdate (____/____/_____)**
- **Child's Age_____**
- **Child's Grade and School (**if applicable**)_____**

Gender

- **Male_____**
- **Female____**

Address (Street, City, State, Zip)

- **Street_____**
- **City_____**
- **State_____**
- **ZIP Code_____**

Dad/Guardian First and Last Name

- **First Name_____**
- **Last Name_____**

Dad/Guardian Cell/Main Contact Phone Number ( )_____-_____

Dad/Guardian Email Address_____

Mom/Guardian First and Last Name

- **First Name_____**
- **Last Name_____**

Mom/Guardian Cell/Main Contact Phone Number ( )_____-_____

Mom/Guardian Email Address_____

Siblings Names and Ages

_____

_____

_____

_____

_____

Which of the following best describes your child's living arrangements?

- **Resides with Dad and Mom_____**
- **Resides with Dad only_____**
- **Resides with Mom only_____**
- **Resides with Dad and Mom in a Divorce/Blended Family Dynamic_____**
- **Resides with family caregiver (sibling, grandparent, aunt/uncle, etc.)_____**
    - **If so, please explain_____**
- **Resides with non-family caregiver_____**
    - **If so, please explain_____**

Can we share the information on this form with other ministries at Faith Community Church that includes your child

- **Yes_____**
- **No_____**

EMERGENCY CONTACTS

<u>Emergency contacts must be different than the parents and should be familiar with the child's habits and conditions. The emergency contacts will be contacted if we cannot reach either parent.</u>

Emergency Contact #1 First and Last Name

- **First Name_____**
- **Last Name_____**
- **Emergency Contact #1 Relationship to Child_____**
- **Emergency Contact #1 Phone Number ( )_____-_____**

Emergency Contact #2 First and Last Name

- **First Name_____**
- **Last Name_____**
- **Emergency Contact #2 Relationship to Child_____**
- **Emergency Contact #1 Phone Number ( )_____-_____**

Child's Diagnosis…check all that apply.

ADD_____ Attention Deficit Disorder	**ADHD_____** Attention Deficit Hyperactivity Disorder
Autism Spectrum Disorder_____	**Anxiety Disorder_____** **Selective Mutism_____**
Behavioral & Emotional Disorder_____	**Bipolar Disorder_____**
Eating Disorder___Sleep Disoerder___	**Neurodevelopmental Disorder**
FASD_____ Fetal Alcohol Spectrum Disorder	**OCD_____** Obsessive Compulsive Disorder
ODD_____ Oppositional Defiance Disorder	**PDD** Pervasive Developmental Disorder
PTSD_____ Post Traumatic Stress Disorder	**SPD_____** Sensory Processing Disorder
Interoceptive Under Responsivity Disorder_____	**Slow Processing Disorder_____**

Asthma_____ **Underdeveloped Lungs_____**	**Brain Injury_____** **In utero_____ Other_____**
Cancer_____Leukemia_____	**Cerebral Palsy_____**
Developmental Aphasia_____	**Diabetes_____**
Downs Syndrome_____	**Dyslexia_____**
Epilepsy_____History of Seizures____ **Controled_____**	**Hearing Impairment_____**
Heart Condition_____	**Learning Disability_____**
Lyme Disease_____	**Memory Loss____Short Term_____**
Minimal Brain Disfunction_____	**Multiple Sclerosis _____**
Muscular Dystrophy_____	**Orthopedic Impairment_____**
Speech Impairment_____	**Visual Impairment_____**

Other_____

- **SYMPTOMS**

Concrete Thinker_____	**Difficulty linking cause and effect____**
Faulty Logic_____ **Lacking Critical Thinking Skills**	**Does not have abstract thinking skills_____**
Struggles to self soothe or self regulate____(circle all that apply)	**Easily overwhelmed by invironment___**
Impulsive_____	**Struggles to manage emotions_____**
High pain tolerence_____	**Low pain tolerence_____**
Struggles to connect voice fluctuations_____	**Struggles to connect action and force_____**
Inconsistent performance_____	**Goes from 0 to 10 in seconds_____**
Struggles to differentiate between external thoughts and events_____	**Struggles to focus and concentrate_____**
Unable to apply previously learned rules to a new situation_____	**Difficulty holding two or more concepts together_____**
Scared of heights or falling_____	**Delayed in respective language_____**
Needs consistent and constant routines and repetition in a structured invironment_____(circle all that apply)	**Needs constant supervision and has no sense of stranger awareness_____**
Transitions are a struggle_____	**Struggles with spacial awareness____**

Hyper - mobile joints_____	**Aversion to physical touch_____**

- **SENSORY**

Auditory	**Hyposensitive_____**	**Hypersensative_____**
Proprioception	**Hyposensitive_____**	**Hypersensative_____**
Smell	**Hyposensitive_____**	**Hypersensative_____**
Tactile	**Hyposensitive_____**	**Hypersensative_____**
Taste	**Hyposensitive_____**	**Hypersensative_____**
Vestibular	**Hyposensitive_____**	**Hypersensative_____**
Vision	**Hyposensitive_____**	**Hypersensative_____**

Over Responsivity_____	**Under Responsivity_____**
Sensory Seeking_____	**Other_____**

- **If needed, please share additional details related to your child's cognitive ability:**

_____

_____

_____

_____

- **COMMUNICATION AND COGNITION**

My child communicates in the following ways:

- **Non-verbal_____**
- **Says words but limited vocabulary____**
- **Verbal_____**
- **Verbal but may be difficult to understand____**
- **Uses pictures to communicate____**
- **Uses a communication device_____**
- **Uses sign language____**
- **Other_____**

Does your child read?_____

Does your child write?_____

Does your child use hearing aids?____

Which of the following best describes your child's ability to follow directions? (check all that apply)

- **Child typically follows directions_____**
- **Child follows simple, one-step directions____**
- **Child follows two-step directions_____**
- **Child is unable to consistently follow directions____**

If needed, please share additional details related to your child's ability to follow directions:_____

_____

_____

_____

_____

_____

- **MOBILITY**

Which of the following best describes your child's mobility?
(check all that apply)

- **Child walks independently____**
- **Child uses a wheelchair_____**
- **Child uses braces or orthotics (describe below)_____**

_____

_____

- **Child uses an assistive device (describe below)_____**

_____

_____

Please describe any special positioning needs, mobility assistance devices, or mobility issues:_____

_____

_____

- **Child has a Service Dog or Therapy Pet_____**
- **Animals Name_____**
- **Animal Kind and Breed_____**
- **Is there anything else that would be beneficial for us to know about your pet?_____**

_____

_____

_____

- **MEDICAL**

Does your child experience side effects from his/her medications that we should know about?

- **Yes(please explain)_____**

_____

- **No_____**

- **My child is not on medication____**

Does your student have allergies to medication?

- **Yes, allergic to penicillin____**
- **Yes, allergic to aspirin_____**
- **Yes, details listed below_____**
- **No allergies to medication____**

Please describe any CURRENT respiratory concerns your student has:_____

_____

Please describe any CURRENT cardiac concerns your student has:_____

_____

Please describe any assistance needs and/or other medical concerns:_____

_____

- **NUTRITION AND DAILY LIVING**

Please list all food allergies (mark n/a if none):_____
_____
_____

Does your child feed him/herself or require assistance? Please describe:

_____
_____

My child has special food issues (check all that apply)

- **Liquid diet____**
- **Soft diet_____**
- **Needs assistents____**

Does your child have difficulty swallowing?

- **Yes_____**
- **Yes, has a tendency to choke____**
- **No_____**

Please list any other dietary restrictions:_____

_____

Please list any food preferences:_____

_____

Which of the following best describes your child's toileting?
(check all that apply)

- **Independent_____**
- **Needs Reminders____**
- **Needs Assistence____**
- **Has Regular Accidents____**
- **Has Periodic Accidents____**
- **Rarely Has Accidents_____**
- **Does Not Have Accidents____**

- **SOCIAL/BEHAVIORAL SYMPTOMS**

What behavioral tendencies does your child have? (check all that apply)
Tantrums____ Running away____ Yelling_____ Biting_____

Pushes_____ Hitting___ Struggles to follow directions____

Destroy property____ Self Harms_____ Confabulates____

Perseverates words___ Has Ticks____ Does Rote Repetitions____

Other (please describe)_____

_____

<u>Describe any other symptomatic behavioral tendencies:</u>

_____

_____

What Triggers These Symptoms?_____

_____

_____

What interventions are beneficial for these symptoms?_____

_____

_____

What accommodations are beneficial for your child?_____

_____

_____

Does your child have any special fears?_____

_____

_____

What things or activities does your child like?_____

_____

_____

What things or activities does your child dislike?_____

_____

_____

Does your child have any hobbies or talents?_____

_____

_____

What are your child's strengths?_____

_____

_____

We should contact you if:_____

_____

_____

_____

Additional comments_____

_____

_____

_____

_____

_____

My child can be photographed in group activity settings for the purpose of sharing on public formats to advertise our churches events and ministries.
Yes____
No_____

Thank you for taking the time to fill out this in depth form!
It is incredibly helpful information for us going forward so we can provide a safe and accommodating atmosphere for your child to learn about God to the best of their cognitive ability. I look forward to meeting with you in person at church to compile a specific plan for your child.

Please email me at rachel@faithjanesville.org to set that up 🙂

Blessings,
Special Needs Director Rachel Martin