Johnson Academy of Therapeutic Learning

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INITIAL PHONE CONSULTATION/ASSESSMENT PLAN — SCHOOL AGE CHILD

Student Name: ______________________ **Date of Birth** __________
School: ______________________ **Age:** __________
Teacher: ______________________ **Grade:** __________

Parent's Name: ______________________ **Email:** __________
Home Phone #: ______________________ **Cell Phone #:** __________

Please circle if any of the following have been diagnosed:
Reading Disorder (dyslexia) Mathematics Disorder Sensory Processing Disorder Language Disorder
Speech Disorder Apraxia of Speech Autism Seizure Disorder Anxiety Depression

If so, indicate name of professional who diagnosed: ______________________
When: ______________________

Current Issues/Problems at school: ______________________

Teacher's Comments/Concerns: ______________________

Parent Concerns: ______________________

Specific Subjects/Academic areas child is struggling with:
Reading Reading Comprehension Spelling Math Other __________

Current and/or Past Services Received: ______________________

Testing and or IEP Results (list names of assessments/dates adminstered): __________

Referred By: ______________________

Test(s) Recommended: __________ **Program Recommendations:** __________

Received By: ______________________ **Date:** __________

Scheduled: yes | no **Appointment Date/Time:** __________