



Family Name: _____

Form Received: _____

Group: _____

For Office Use Only

Social Skills Group—Client Profile

The information on this profile is kept confidential. It is used only to assist us in the development of program goals for your child.

Name: _____ D.O.B. ___/___/___

Address: _____

Parents/Guardians: _____ Home Ph: _____

Mother: Work Ph. _____ Mobile: _____ Fax: _____

Father: Work Ph. _____ Mobile: _____ Fax: _____

Email: _____

Emergency Contacts:

1. _____ Relationship to child: _____

Ph. _____ Mobile: _____ Email: _____

2. _____ Relationship to child: _____

Ph. _____ Mobile: _____ Email: _____

Allergies:

Food Allergies/intolerances: _____

Environmental intolerances: _____

Other allergies/intolerances: _____

Medications: _____

Diagnosis:

At what age was your child diagnosed: _____

Does your child know their diagnosis? _____

Are there suspected, undiagnosed disorders? _____

Does your child have any learning difficulties? _____

Reading level: _____

Writing ability: _____

Which does your child prefer: Handwriting Using laptop Adult scribing

Does your child like to draw? Yes No

Attention span: Poor Fair Good

Memory/Recall Poor Fair Good

If the following are relevant please specify what they are or how they affect your child:

Obsessive interests: _____

Collecting/Hoarding: _____

Self stimulatory behaviours: _____
(eg. Flapping, flicking objects, chewing, mouthing objects, rocking, spinning)

Speech: None Poor Fair Good Excellent

Specific language problems: _____

Prosody Pedantic Interrupting Swearing

Vocal tics Unclear speech Perseveration (goes on and on)

Comprehension: None Poor Fair Good Excellent

Have your or do you use the following:

PECS Used: Currently / Previously / Never (please circle)

Compics Used: Currently / Previously / Never

Other Used: Currently / Previously / Never

Physical coordination: None Poor Fair Good Excellent

Muscle tone: None Poor Fair Good Excellent

Balance: None Poor Fair Good Excellent

Motor tics: Yes No

If so, please describe: _____

Energy level: Low Normal High

Activity Level: Low Normal High

Motivation: Low Normal High

Compliance/cooperation: _____

Comments: _____

Challenging behaviours:

(please give details about degree of behaviour and what triggers it—e.g. situations, places, people. Also, what helps to stop behaviour?)

Aggression:

Screaming:

Self-injury:

Absconding:

Swearing/Abusive speech:

Sensory Profile:

(Please give as much specific detail as you can about how your child tolerates different sensory experiences, whether reactions are normal, or unusual, and please list specific likes and dislikes).

Noise:

Sounds:

Smells:

Lights/colours/visual:

Taste:

Food Textures:

Touch:

Groups/crowds:

Temperature changes:

Clothing:

Art materials:

How does your child cope with change? What helps to prepare him for transition?

What are your child's preferred activities at home?

Favourite cartoons and TV shows: _____

Favourite electronic games: _____

Favourite computer games: _____

Anxiety level: Low Moderate High Extreme

What triggers anxiety: _____

What reduces anxiety: _____

Specific fears/phobias: _____

Does your child experience 'meltdowns' - periods of extreme distress? What happens and what are common triggers? What helps to calm your child?

What do you hope that your child will gain from attending a social skills group?

Do you have any particular concerns about your child, or any issues or behaviours that you would like help in managing?

Please share any other information that you think is important or helpful for us to know:

Form completed by: _____ Date: ___/___/___

Thankyou for your time.