

Missy Silver - Educational Therapist
yearning4learning1@gmail.com
www.Yearning4Learning.net



Phone: (415) 517-4213
Address: 91 Cragmont Ave
San Francisco, CA 94116

Pre-Service Questionnaire

Please fill-out this form as completely as possible. Your answers will help us to serve the student more effectively. All information is strictly confidential.

General Information

Student's Name: _____ Sex: M ___ F ___ Home
address: _____

Telephone #: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

Referred by: _____ Title: _____

Name of person completing this form: _____ Date: _____

Statement of Concerns:

What concerns brought you in today? _____

When did you begin to become concerned and why? _____

Did anything in particular cause the situation that concerns you? _____

What is your child's understanding of why you are here today? _____

What are your child's feelings about coming here? _____

Has the student ever been tested or received special academic or behavioral help ? Yes _____ No _____ If yes, please describe the type of service, the school or agency which rendered service and the dates of the service.

Type of Service

School or Agency

Dates

<u>Type of Service</u>	<u>School or Agency</u>	<u>Dates</u>

Family History

Parent/Guardian's Name: _____ Marital Status: _____

Address: _____

Occupation and Name of Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Last Schooling Completed: _____

Any history of learning difficulties? (if yes, please explain) _____

Parent/Guardian's Name: _____ Marital Status: _____

Address: _____

Occupation and Name of Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Last Schooling Completed: _____

Any history of learning difficulties? (if yes, please explain) _____

Have any of your other children or family members experienced learning problems, hearing problems, or speech/language problems? _____

Main Language spoken at home: _____

Other languages spoken at home: _____

School History

List, in order, the schools the student has attended:

School	City	Grade Level	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical/Developmental History

Pregnancy

How would you describe the pregnancy? _____

Did the Mother experience any illnesses, accidents, shocks, mental or physical strain, or any other complication during pregnancy? (if yes, please describe) _____

How would you describe the birth? Were there any difficulties or complications? _____

Was the baby full term? _____

Early Years and Overall Health

What kinds of childhood illnesses did your child have? _____

Were there any instances of high fevers or convulsions? _____

Were there any head injuries or loss of consciousness? _____

Has your child ever been on any medications? _____

Does your child have difficulty sleeping? _____

Describe your child's appetite. Any food allergies? _____

Does your child have any coordination problems? If so, explain: _____

How would you describe your student's overall health? _____

Date of most recent Physical: _____ Eye Exam: _____ Hearing Exam: _____

Please check any of the developmental milestones that came late for your child.

Babbling: _____ Speaking Single Words: _____ 2-3 Word Combinations: _____ Reading: _____ Writing: _____

Social/Emotional History

Has your child ever had emotional or behavioral problems? (if yes, please describe): _____

Please describe the student's attitude toward the following:

Brothers and sisters: _____

Playmates and peers: _____

Does your child prefer to play alone or with other children? _____

Does your child play easily with other children? (if no, please describe): _____

What does your child like to do when they are not in school? _____

Feelings/Attitudes Toward School

What are your child's favorite subjects in school? _____

What are your child's least favorite subjects? _____

In general, what is your child's attitude toward school? _____

About how many days a year is your child absent from school? _____

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Release of Information Form

Name of Student: _____

I hereby release Missy Silver to discuss pertinent information of the above-mentioned student with other educational or therapeutic professionals who work with the student for the purpose of better serving this student. These professionals may include but are not limited to the student's teacher(s), occupational or speech/language therapist(s), psychologist(s) or pediatrician. I understand that any discussions will be handled with the greatest respect for the individual and the individual's privacy. I further understand that any information shared is held in absolute confidence between **Missy Silver** and said professionals.

I understand that I may at any time withdraw permission to share the student's information with educational or therapeutic professions, either jointly or severally at any time, by writing a letter to **Missy Silver**.

Signature: _____ Relationship: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____

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Emergency Information

Name of Student: _____

Address: _____

Parent/Guardian Home Phone:	Parent/Guardian Home Phone:
Parent/Guardian Cell Phone:	Parent/Guardian Cell Phone:
Parent/Guardian Work Phone:	Parent/Guardian Work Phone:
Parent/Guardian Email:	Parent/Guardian Email:

Name of Physician: _____ Phone: _____

Hospital: _____ Phone: _____

Pertinent Medical History: _____

Allergies: _____

Emergency Contacts:

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

In the event that a parent/guardian of family member can not be reached, I give my permission for _____ (name of student) to receive the necessary medical services and/or to call an ambulance. The undersigned person(s) will be responsible for medical/ambulance expenses.

Signature: _____ Relationship: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____



Business Policies

I. Commitment

In order to achieve the goals we have established, we strongly encourage **consistent** attendance. While we understand that there are times life gets busy, your child will experience the best results by coming to all planned sessions on time and for the complete duration.

please initial _____

II. Cancellations

If you give at least twenty-four hour notice, you will not be charged for canceling a session. Without twenty-four hour notice, payment for the missed session will be expected at the next session. If you are late for a session, the session will still end at the appointed time and you will still be charged for a full session.

please initial _____

III. Payment Schedule

Most commonly, payment is expected at the time of a session. In certain situations and with previous agreement, clients may opt to pay monthly, at the end of the month.

please initial _____

IV. Holidays

This practice is closed for all National Holidays. Other vacation times will be arranged at the discretion of the Educational Therapist. Ample notice will be provided.

please initial _____

V. End of Services

Educational therapy forms a strong relationship between student and educational therapist. Termination of services does not allow for closure between student and educational therapist. Please schedule at least one additional session prior to termination.

please initial _____

VI. Billing

Billing is done at the end of each month and payment is due on the last session of each month.

please initial _____

VII. Attendance

Consistency in attendance is a primary factor in achieving educational growth. Your child's sessions are considered standing appointments. This special time is a commitment on your part and mine.

please initial _____

VIII. Cancellations

Parents/Guardians are financially responsible for all sessions except for legal and religious holidays. However, during vacation periods, there is no charge for absence if adequate notice is given. Cancellations with less than 24 hours notice or non-notified cancellations will be charged without a make-up session. For sessions that are cancelled in advance, a make-up session cannot be guaranteed, but every effort will be made to provide one at a mutually convenient time.

please initial _____

I have read, understand and agree to abide by to the four points of the business policy for Yearning4Learning.

Signature: _____ Date: _____

Print Name: _____

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Schedule of Fees

Yearning 4 Learning takes pride in the personalized, research-based support we are able to offer your child. Helping your child feel confident and love learning is our ultimate goal.

- Initial Intake /Assessment/Parent Meeting \$205.00
- School/Home Observation \$220.00
- Educational Therapy \$205.00 for 50-minutes
- Communication (in-person, written or phone) under 10 min free, over
10 minutes is prorated at
\$205.00/hr

Includes a written educational plan, including individualized goals.

- A session is 50 minutes. Please come on time, so we can get as much as possible out of each session.
- If you give at least twenty-four hours notice, there is no charge for a missed session.
- In order to foster communication, we will have a parent meeting near the beginning of service and approximately once a semester, or at the request of parents. Parent meetings will be charged at the standard session rate.

I have read, understand, and agree to the above-stated fees and the conditions of this educational therapy practice.

Signature: _____ Date: _____

Print Name: _____ Relation: _____

Signature: _____ Date: _____

Print Name: _____ Relation: _____