



Mercer Island School District

# Early Childhood Child Find Intake Form

For best results when filling out this form on your computer,  
download it first and open in Adobe Acrobat Reader or the equivalent.

Date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Child's birth date: \_\_\_\_\_  
(mm/dd/year)

Parent 1 name: \_\_\_\_\_ Parent 2 name: \_\_\_\_\_  
*Last Name First Name Last Name First Name*

Address: \_\_\_\_\_

Parent 1 email: \_\_\_\_\_ Parent 2 email: \_\_\_\_\_

Parent 1 phone numbers: (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Parent 2 phone numbers: (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Student's primary language: English ☐ Other, please specify: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Languages spoken at home: \_\_\_\_\_

Current preschool: \_\_\_\_\_ At what age did child enter preschool? \_\_\_\_

Did the student ever receive B-3 services Yes ☐ No ☐ Kinderling ☐ Boyer ☐ Other, please explain: \_\_\_\_\_

If so please attach paperwork (IFSP, Evaluation, etc.)

**Please describe current concerns: (academic, social/emotional, behavioral, medical, etc.)**

Problems or difficulty sleeping, frequent nightmares, sleepwalking, nail biting, stuttering, teeth grinding, oral fixations etc.?

☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

**Check any characteristics or behaviors that may apply to your child:**

- ☐ Shy ☐ Withdrawn ☐ Low energy ☐ Aggressive (i.e. hits, bites, kicks)
- ☐ High energy ☐ Impulsive ☐ Happy ☐ Friendly ☐ Affectionate ☐ Sad
- ☐ Difficult to console ☐ Curious ☐ Prefers to play alone ☐ Easily frustrated
- ☐ Frequent temper tantrums ☐ Picky eater ☐ Sensitive to loud noises

**Other concerns:**

**Medical/Developmental History:**

Child's condition at birth: ☐ Full term ☐ Premature Child's birth weight: \_\_\_\_\_

Complications during pregnancy or delivery: ☐ Yes ☐ No If yes, please explain:

Drugs/Alcohol/Smoking during pregnancy: ☐ Yes ☐ No If yes, please describe:

Significant hospitalization or medical history (for child) ☐ Yes ☐ No If yes, please describe:

Approximate age when child: *Please note that not all preschool aged children may have met these milestones – write N/A to indicate 'not at this time'*

Sat independently: \_\_\_\_\_ Used words: \_\_\_\_\_ Crawled: \_\_\_\_\_ Walked: \_\_\_\_\_

Used sentences: \_\_\_\_\_ Dry at night: \_\_\_\_\_ Toilet trained: \_\_\_\_\_

Ate independently: \_\_\_\_\_ Drank from a cup: \_\_\_\_\_ Used utensils: \_\_\_\_\_

Do you feel that your child's development has been equal to their peers?

☐ Yes ☐ No If no, please describe:

Medical/psychological evaluations or diagnoses:

Current private therapies: (e.g., speech, OT, PT, counseling, ABA, play therapy)?

☐ Yes ☐ No If yes, please describe:

Referral Source: ☐ Parent ☐ Preschool ☐ Other, please explain: