SOARING SKILLS LLC.

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608-632-6790
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Soaring Skills Client Intake Form

Client Information:

Last Name _____ First Name _____ DOB_____

Address _____

Best Contact _____

Phone Number _____ Email Address_____

Parent / Guardian Information (if applicable):

GUARDIAN 1
Last Name _____ First Name _____

Address _____

Phone Number _____ Email Address_____

GUARDIAN 2
Last Name _____ First Name _____

Address _____

Phone Number _____ Email Address_____

What County do you receive services from? _____

What program do you receive services through (CCS, CLTS)? _____

Who is your case manager? _____

What are the clients strengths? _____

_____

_____

Medical issues, mental health and or any diagnosis: (please list all that apply with detail, medication, allergies, food allergies)

_____

_____

_____

_____

Does the client have an IEP or 504 Plan? _____

Does the child have a behavior plan at school at school? If so, please provide a copy and details to plan:

_____

_____

_____

_____

What school does the client attend? _____

Has the client ever had a juvenile sanctions referral/Law enforcement referral? Is so please give details:

_____

_____

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_____

What CCS and or CLTS Goals or Outcomes would Soaring Skills be working on with the client?

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Point of contact for setting up appointments _____

_____

Any other information Soaring Skills should know about the client to help them be successful:

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