

Group Connections
The Morgens Group, LLC

Pragmatic Group Information Form



Today's date: _____

Child's Name: _____ Birthdate: _____ Age: _____ Sex: _____

Address: _____
No. & Street City State Zip Code

Who referred your child? _____ Phone #: _____

Why was your child referred? _____

Please list why you would like your child to participate in our group program as well as any questions you may have:

1. _____
2. _____
3. _____

Parent/Guardian Information:

Parents' Marital Status: Single Married Divorced → Date: _____ Widowed → Date: _____

Mother's Name: _____ Father's Name: _____

Mother's DOB: _____ Father's DOB: _____

Home Number: _____ Home Number: _____

Address: _____ Address : _____

Last Grade/Degree Completed: _____ Last Grade/Degree Completed: _____

Occupation: _____ Occupation: _____

Work Number: _____ Work Number: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

If parents are divorced, what is the custody arrangement? _____

Who lives in Child's home? (Please include parents, siblings and others and their ages): _____

Child's School History Information:

Current School: _____ Grade: _____

School Address: _____

School Phone Number: _____ Teacher: _____

Contact Person (*child's advocate or program director*): _____ Role: _____

Has your child ever repeated a grade? _____ Which grade? _____ Why? _____

Please describe your child's educational setting (if he or she is mainstreamed, in special education or at a special school. If he or she is in a partial special program, please describe which classes are mainstreamed and which ones are not, as well as any special services your child receives and how often): _____

Please describe any learning difficulties (LD) that your child may be experiencing: _____

Please describe any behavioral or social difficulties that your child may be experiencing: _____

Child's Individual Medical/Therapy History Information:

Current Physician: _____ Phone Number: _____

Other Physician (Psychiatry): _____ Phone Number: _____

What is the nature of the visits? _____

MEDICAL / PSYCHOLOGICAL CONDITIONS (DIAGNOSIS) LIST

Please list all current psychological and medical diagnoses including current medical procedures.

Indicate date when problem is resolved.

Date	Problem	Date Resolved

MEDICATION LIST

List all current medications. Indicate date when medication is discontinued.
NOTE: This is a record of prescribed medications, not a physician order sheet.

Date	Medication	Dose/Frequency	Prescribing MD	Date Resolved

DRUG / FOOD ALLERGIES OR ADVERSE REACTIONS: _____

THERAPY HISTORY

Please include: dates, length of time, therapist or organization, nature of the therapy, and relevant diagnoses.

Dates Attended

Therapist / Nature of Therapy / Relevant Diagnoses

Current Therapist/Counselor: _____ Phone Number: _____

What is the nature of the visits? _____

How long has your child been in therapy with this therapist? _____

Please list the child's history of evaluations:

TYPE	FACILITY	EXAMINER
Speech-Language		
CORE		
Psychological / Neuropsychological		
Other:		

Please share any other information you feel we need to know in determining your child's appropriateness for the Group Program. Thank you.