

Special Education Law and Advocacy
Initial Client Information Form

Individuals who have obtained an appointment for an initial consultation may submit their client information in advance of their appointment, by filling out and submitting the following information. This form is specifically designed for individuals, who are seeking assistance for children with disabilities in public school. Individuals seeking different services may disregard irrelevant questions.

Client Name (First, Middle Initial, Last)

Client Mailing Address

Street & Apt #

City, State, Zip Code

Spouse or Significant Other's Name

Information on Child requiring services
Telephone, Fax & Email Information

Telephone # Cell Phone #

Fax # Email Address

Child's Name:

Date of Birth:	Age:	Grade:

School District (County)

School Name

District Contact Person:

Highest ranked Individual you have spoken with about your issues

Name:

Telephone #:

Child's Disability:

This portion of the form is intended to provide the maximum amount of information possible on your child and his/her disability. We are sensitive to the fact that your child is a unique individual and our purpose is not to categorize or label your child. In your initial consultation, we will ask many more questions, in order to have a full understanding of your child.

Primary Disability:

Secondary Disability:

Other:

Other:

Additional Description of the Child's Disability:

Educational Documentation and Evaluations

Date of most recent IEP: _____

Date scheduled for next IEP: _____

Evaluations: Please indicate which of the following evaluations have been done on your child.

Most Recent Date for the Following Evaluations:

Physiological/Educational _____

Functional Behavior Assessment _____

Physical Therapy _____

PBSSP (BIP) _____

Occupational Therapy _____

Assistive Technology _____

Speech/Language _____

Intellectual Level (I.Q.) _____

Services presently being provided:

Please check which of the following services are presently being provided to your child, by the school district. Next to the service indicate the amount of time, per week, your child is receiving each service.

- Special ESE Class (full time)
- Special ESE Class (part-time) Time: _____
- Speech/Language Time: _____
- Physical Therapy Time: _____
- Occupational Therapy Time: _____

Areas of Concern and Issue with School: Please check which of the following areas are concerns or issues, which you would like to see addressed.

- Behavior Issues
- Inclusion or Educational mainstreaming
- Paraprofessional Assistance
- Speech/Language
- Assistive Technology
- Occupational Therapy
- Physical Therapy
- RtI Issues

Statement of Issues: Please provide a statement of the principle issues that you wish addressed:

How did you hear about our firm? _____

Thank you and we look forward to working with you.

The SELA Team

For Office Use Only:

___ Representation Agreement

___ Consent Form

