

For Office Use Only

Date Received _____
Appt. Scheduled _____

INTAKE FORM

Please fill out this form and mail to us. If your child has had any previous evaluations, please also mail that information as well two weeks before your appointment. Please include a recent photo of your child.

Section I - Identifying Information

Child's Name:	Birth date:	Sex:
Address:		
(Please supply 2 addresses if parents have separate residences)		
Home telephone:	Email address:	
Self-Referred/Referred by:		
Pediatrician:		
Diagnosis (if known):		
Why are you bringing your child for a neurodevelopmental evaluation? What are your concerns?		

Section II - Family Information

Mother:	Birth date:
Employer:	Occupation:
Employer's address:	Phone:
Cellular telephone:	
Furthest level of education:	
Known physical or mental health disorders:	
Difficulty with:	Learning: yes no
	Speech: yes no
	Hearing: yes no
	Coordination: yes no
Handedness:	

Father:	Birth date:
Employer:	Occupation:
Employer's address:	Phone:
Cellular telephone:	
Furthest level of education:	
Known physical or mental health disorders:	
Difficulty with:	Learning: yes no
	Speech: yes no
	Hearing: yes no
	Coordination: yes_ no

Handedness:			
Siblings and other household members:			
Name:	Relation to child:	Age:	Problems:
Foreign languages spoken in the home:			
Has anyone in the family (mother's or father's side, including cousins) had any significant medical, neurological, psychiatric, speech or learning difficulties?:			
Section III - Interventional History (EI, Preschool, or School Age)			
Early Intervention:			
Name of Program/Provider:			
Age began program:			
Therapies received & frequency (please see page 2):			
Preschool Program (special ed or mainstream?):			
Name of Program/School:			
Hours at school:	Days per week:	SEIT or 1:1 aide:	
Ages attended:			
Therapies received & frequency (please see page 2):			
School Age Placement:			
School Address:			
Grade:	Hours at school:	Days per week:	
Class setting (Mainstream, Inclusion, Self-contained special education, other?):			
Ratio students:teacher (if known):			
Resource Room:			
Classification:		Last evaluation:	
Therapies received & frequency:			
		PT:	
(please indicate if any therapies are private)		OT:	
		Speech :	
		ABA/VB:	
		Floortime:	
		SEIT hours:	
		Other:	

Section IV – Pregnancy history
Age conceived: times pregnant: miscarriages:
Did you have use of assisted reproductive technology?:
Health during this pregnancy:
Illnesses: Accidents:
Diabetes, infection, hypertension, bleeding?:
Drugs/alcohol:
Medications/vitamins taken:
Any difficulties:
Length of pregnancy:
Labor and Delivery:
Birth hospital:
Length of labor: medications given:
Problems/comments:
Delivery: anesthesia used:
Normal: induced: forceps:
C-section (if yes, why?):
Position at birth: head first: feet first: problems during delivery:
Birth weight: length: Apgars:
Neonatal care
Regular nursery: ICN:
Jaundice: did baby need lights?:
Did the baby: turn blue:
have difficulty breathing:
needed a respirator: how long:
have seizures: meds:
have muscle tremors:
have difficulty feeding:
details on any of the above:
How old was the baby when he/she came home?:
Section V – Medical History
Describe any serious illnesses, injuries, hospital stays or operations: Has your child ever had an MRI, CAT Scan of the brain, EEG, or genetic testing?:
Has your child been followed by or evaluated by other medical specialists (i.e. Geneticist, GI, Neurologist, etc.)?:
Review of Systems
Does your child have or has your child had any of the following?:

Frequent ear infections:
High fevers:
Seizures:
Serious infections:
Head injury:
Tics or nervous habits:
Asthma:
Heart Defect or heart murmur:
Trouble gaining weight:
Headaches:
Stomachaches:
Diarrhea:
Constipation:
Excessively dry skin:
Rashes:
Hair loss:
Bruises easily:
Broken bones:
Environmental Allergies:
Allergies to medication:
(If yes to any of the above, please describe)
Did your child have any developmental regression? (lose skills he/she had):
Immunizations, are they up to date?:
Any adverse reactions?: (if yes, please explain):
Does your child have allergies or food intolerances:
Medications or supplements with doses (please list):
Vision: good poor formally tested? glasses?
Hearing: good poor formally tested? when?
Section VI – Developmental Milestones (as best as possible, give ages when child did each of the following:
Gross motor – Fill in Age Attained
rolled stomach to back:
rolled back to stomach:
sat without support:
crawled on all fours:

cruised furniture:
walked independently:
walked up stairs: alternating:
walked down stairs: alternating:
pedal tricycle:
jumped on one foot:
rode bicycle:
Fine motor - Fill in Age Attained
swatted at mobiles in crib:
transferred from hand to hand:
held bottle:
fed self with fingers (pincer):
did simple puzzles:
used spoon: fork cup
Scribbled: what hand
colored in line:
cut with scissors:
dress/undress:
did closures: buttons zippers tied shoes
Adaptive - Fill in Age Attained
baby food: difficulty introducing
cup drinking: difficulty introducing
table food: difficulty introducing
Toilet trained: dry at night
Speech - Fill in Age Attained
turned to sound:
recognized mother:
recognized familiar voices:
social smile:
cooed:
babbled:
played games (peek-a-boo, so-big, Pat-a-cake):
pointed to body parts:
first words:
two word phrases:
simple sentences:
recites (count to 10, sings alphabet, etc):
recognized colors: named colors
recognized shapes: named shapes
recognized numbers: named shapes
Section VII – Present Development
Height: Weight:
Teeth: good fair poor seen by dentist when?
Drools: yes no Thumb/finger sucking?: yes no

your pediatrician):	
Please list names and addresses:	
Name of insured:	Signature:
Insurance plan name:	Relation to child:
Policy #:	Insured's Social Security #:
Group #:	Date:
NOTE: Payment of services is expected at the time of the evaluation unless other arrangements are made. A report will not be issued until final payment is received.	