Patient Name: _____

DOB: _____

Date of Intake: _____

Referral Source: _____

Insurance ID #: _____

REASON FOR REFERRAL: _____

_____

_____

_____

_____

FAMILY INFORMATION:

Parent Names: _____

Married / Single Divorced, custody?

Parent Employment: Mother _____

Father _____

Step parent? _____

COMMUNITY PROVIDERS:

Pediatrician:

Name: _____ Practice: _____

Address: _____

Phone: _____

Email: _____

Other:

DIAGNOSIS:

Diagnosis	Date of diagnosis	Physician	Medication	Other Tx	Active?

MEDICATIONS:

PATIENT HISTORY

Developmental

Pregnancy

risk factors in pregnancy(Y/N)_____
complications in pregnancy(Y/N)_____
medications taken during pregnancy(Y/N)_____

Birth

full-term or premature: _____ weeks_____weight_____

Vision difficulties: Y / N Explanation: _____

Hearing: Y / N Explanation: _____

Developmental Milestones

Social:	**Motor:**	**Language:**	**Self-help:**
Used gestures (wave, bye-bye):	Sat alone:	Babbled:	Toileted (day)
Pretend play:	Crawled:	1st word:	Toileted (night)
Cooperative play:	Walked alone:	2-3 word:	Undress self:
			Dress self:

Sleep issues: _____

Feeding issues: _____

Sensory issues:

Type	Response	Treatment

Medical History:

For any of the above psychiatric/developmental disorders, please indicate treatment:

Diagnosis:	Medication/ Dosage:	Therapy: (Psych, ST, OT, PT)	Ongoing? (Y/N)

Hospitalizations:

Date: _____ Dx: _____ Length of stay: _____
Date: _____ Dx: _____ Length of stay: _____
Date: _____ Dx: _____ Length of stay: _____

Other medical physicians involved in care: (Y/N) If yes, please identify

Name: _____ Practice:_____
Specialty: _____ Address: _____
Phone: _____ _____
Email: _____

Family History

Is there a history of medical conditions, mental health difficulties, atypical development or problems with learning in the patient's family? (Y/N)_____ If yes, please specifiy_____

_____

Educational History

Has your child ever been placed in EP? Y / N
Please check the type of special education placement:

_____OHI _____Autism/PDD _____OI _____HI _____VI _____EBD _____SEBD

_____MID _____MOID _____SID _____PID _____LD _____TBI _____SDD

Previous Testing:

Date	***Place***	***Results***	***Recc***

Does your child have an active IEP or 504 plan? Y / N : _____

_____

_____

Does your child receive IEP-related services? Please indicate the number of minutes per week:

Speech-Language	_____/wk	Transportation	_____/wk
OT	_____/wk	Adaptive PE	_____/wk
PT	_____/wk	Orientation/Mobility	_____/wk
Audiology	_____/wk	Recreation/Therapeutic Recreation	_____/wk
Psychological Services	_____/wk	Other	_____/wk
Counseling	_____/wk		

Emotional/Behavioral Functioning:

Anxiety?

Depression?

Frequent crying: Y / N Irritability: Y / N Sudden emotional (anger, sadness) outbursts: Y / N

Change in sleep patterns? Y / N Change in eating habits? Y / N Changes in personal hygiene? Y / N

Loss of interest in things he/she used to enjoy? Y / N

Has expressed feelings of hopelessness or a low self worth / self confidence? Y / N

Has your child ever expressed suicidal thoughts or acts? Y / N

If so, please explain: _____

How does your child typically cope with emotional distress? _____

How does your child typically express anger or frustration? _____

Socialization/ Leisure

Does your child make friends easily? Y / N If not, please explain: _____

Please use this space to identify any specific questions you have:

1. _____
2. _____
3. _____

Please indicate your goals for this evaluation/ therapy:

1. _____
2. _____
3. _____
4. _____