



Center for Developmental Behavioral Pediatrics

Intake Request (Part 2: Parent/Guardian)

All patients need a physician referral before appointment can be scheduled

Date of Request _____

PLEASE NOTE: The Center for Developmental Behavioral Pediatrics specializes in the assessment of developmental conditions that result in delayed milestones, inability to communicate effectively, learning problems, and poor or atypical social interactions. Evaluation and therapy are also provided. For diagnosis or treatment of disorders that are primarily psychiatric or issues related to child abuse or custody please refer to mental health or psychiatric services.

FOR OFFICE USE ONLY:
Date Received:
Appointment Date Scheduled:

PATIENT NAME

Last	First	Middle
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Patient Date of Birth:		Age:	Sex:	Race:
Patient Street Address:				
Patient Town/City:		Zip Code:	County:	
Home Telephone: (Include Area Code)		Cell Phone:		
Best phone number to contact you Mon-Fri between 9A and 3P:				
Parents or Legal Guardian of Patient:				
Work Telephone:		Message Telephone:		
Primary Care Physician (PCP):				
PCP Telephone:		PCP Office location (town):		
School Child Attends:			Grade:	
What is the primary language spoken in the home?				

Is this appointment a first time visit or a follow up visit?
First Time Visit _____ Follow-up Visit/ Last seen: _____

What do you think are your child's main problems? _____

What have you been told by doctors, teachers, or others about your child's problems? _____

What questions do you want answered from your child's developmental evaluation? _____

Has your child ever had testing to evaluate for learning or developmental problems? If yes: When was testing done? Where was testing done? *Please bring a copy of any prior testing results to appointment.
Please indicate any services your child currently receives: <input type="checkbox"/> Early Childhood Developmental Services <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Self-Contained Classes <input type="checkbox"/> Title I <input type="checkbox"/> Resource (i.e., special education) Classes <input type="checkbox"/> Counseling <input type="checkbox"/> Speech/Language Therapy <input type="checkbox"/> 504 Modifications <input type="checkbox"/> Occupational Therapy Other: _____
Serious illnesses or major medical problems? Please list problems:
Vision Problems? Hearing Problems?
Has your child previously received mental health diagnosis or treatment? If Yes, please list:
Does your child take any medications on a regular basis? If Yes, please list:
<i>Comments:</i> Is there anything else you would like us to know about the child?

Form completed by: _____ **Relationship to child:** _____