12520 Prosperity Drive #210
Silver Spring, MD 20904

301-869-7505
www.PDCandMe.com

17620-A Redland Road
Rockville, MD 20855

INTAKE FORM

Date: _____ Referred by:_____

Child's Name:_____ Gender: Male or Female (circle one)

Child's Date of Birth: _____ Age:_____

Parents' Names: _____

Primary Address: _____

_____

Contact Telephone Numbers and Email Addresses

Parent/Guardian Contact: Gender: Male or Female (circle one)

(H)_____ (C) _____

Parent/Guardian Email:

_____

Parent/Guardian Contact: Gender: Male or Female (circle one)

(H)_____ (C) _____

Parent/Guardian Email: _____

Insurance Information

Insurance Company _____

Name on Policy _____

Insured's ID Number _____ Group Number _____

Insured's Date of Birth_____

Insured's Employer:_____

Relation of client to insured:_____

Parent/Guardian Employer: _____

Address: _____

Work Phone: _____ Work Email:_____

Parent/Guardian Employer: _____

Address :_____

Work Phone: _____ Work Email: _____

Family and Education

Who does child reside with? _____

Age of Siblings: Brothers:_____

Sisters:_____

Which languages are spoken at home (please * the primary language)? _____

If your child is not in elementary school, who cares for your child during the day? _____

Please complete for school/education history

Infants and Toddlers	yes or no	Dates	Services provided
Preschool: yes or no School Name:	private or special education	Dates	List any therapy services provided
Elementary School School Name:	home schooled, private, public school, special education	Completed or Current Grade _____	List any therapy /special education services provided
Post Elementary School School Name:	home schooled, private, public school, special education	Current Grade _____	List any therapy/special education services provided

What specific behaviors or skill deficits demonstrated by your child prompted you to seek an evaluation? _____
_____
_____
_____

PRIMARY CONCERNS:

___ language	___ articulation	___ feeding	___ self-regulation	___ body awareness
___ social skills	___ reading	___ writing	___ sensory processing	___ handwriting
___ strength	___ coordination	___ communication	___ academics	___ self care

Providing additional information is helpful to your child's therapist: _____

_____

*Providing **detailed information** allows your child's therapist to understand a complete picture of your situation from which the most **comprehensive and targeted treatment plan** can be designed and implemented. In addition, insurance companies ask for **proof of medical necessity** for speech therapy and occupational therapy services.*

MEDICAL HISTORY

Please check all that apply and describe in detail below (date, physician, treatment, result):

___ Autism	___ metabolic disorder	___ ear infections
___ Down Syndrome	___ hypotonia	___ concussion/head trauma
___ Cerebral Palsy	___ sensory disorder	___ torticollis
___ ADHD type:_____	___ allergies	___ reflux
___ Developmental Delay	___ frequent colds	___ anxiety
___ hospitalization	___ surgery	__ medications

Description and Details:

The Pediatric Development Center believes that collaboration with all members of your child's developmental and medical team enhances our ability to deliver the best quality of care. Providing the name, address, and medical reports of all professionals with whom you would like us to collaborate can be very helpful. **By signing below you are giving PDC permission to send initial reports, periodic progress updates, and/or speak with the team members.**

Pediatrician: _____

Developmental Pediatrician: _____

Psychologist: _____

Neurologist: _____

Occupational Therapist: _____

Speech Therapist: _____

Physical Therapist: _____

Behavior Specialist: _____

Gastroenterologist:_____

ENT:_____

Other:_____

I, _____, give PDC permission to send initial reports, periodic progress updates, and/or speak with team members provided above.

_____ _____

Signature Date

Breathing, sleep, body awareness, learning, self-regulation, feeding, and toileting can be interrelated. Please check all of the following that apply to your child. ***If your child is under the care of a medical professional for any checked items, please provide that information as well (doctor, treatment, outcome).***

RESPIRATION:

___ audible breathing	___ snores	___ chronic congestion	___ mouth often open
___ mouth breathing	___ enlarged tonsils	___ sinus infections	___ mouths objects/fingers/clothing
___ ear infections	___ enlarged adenoids	___ asthma	other:

Description and Details (Respiration):

SLEEP:

___ difficulty falling asleep	___ wakes gasping	___ mouth open	___ sweats at night	___ restless
___ wakes frequently	___ drools	___ strange positions	___ wets bed	___ daytime drowsiness
___ snoring	___ night terrors	___ holds breath	___ tooth grinding	___ does not sleep alone

Description and Other Observations:

BODY AWARENESS/SENSORY/ SELF-REGULATION:

___ uncoordinated	___ low energy	___ aggression	___ thumbsucking/oral habits
___ floppy	___ high energy	___ difficulty with transitions	___ difficulty with toilet training
___ poor posture	___ fidgets	___ fears/dislikes noises	___ difficulty in group situations
___ easily distracted	___ tantrums	___bothered by clothing/tactile media	___ introvert

Description and Details:

FEEDING:

___ difficulty nursing	___ resistant to new foods	___tongue thrust	___ diet restrictions; medically ordered
___ picky eater	___ coughs during meals	___ constipation	___ reflux
___ food refusal	___ often eats alone	___ vomiting	___ weight loss
___ gags frequently	___ often needs his own meal	___ food allergies	___ poor weight gain
___ has choked	___ must be fed	___ food intolerance	___ obese

Description and Details:

PREGNANCY AND BIRTH: Please check all that apply and provide more information below:

___ normal pregnancy and birth	___ surgery needed	___ induced labor	___ low APGARS
___ bedrest ordered	___ premature birth	___ suction delivery	___ jaundice
___ medication taken	___ multiples birth	___ forceps delivery	___ NICU
___ placenta previa	___ breech	___ c-section delivery	___ feeding tube
___ preterm labor	___ excessively long labor	___ vaginal delivery	other:

Description and Details:

LATE ONSET DEVELOPMENTAL MILESTONES: Please check all that were late and provide information below

___ eye contact	___ sitting unsupported	___ cooing	___ shapes and/or colors
___ sleeping all night	___ crawling	___ babbling	___ ident/naming letters
___ toilet training	___ cruising	___ use of gestures	___ reading
___ tummy time	___ walking	___ first words	___ writing
___ rolling	___ pretend and/or peer play	___ combining words	___ language comprehension

Description and Details (Developmental Milestones):

HEARING AND VISION:

Audiological Evaluation	**Date**	**Place**	**Result**
Screening at school or doctor			
Audiologist			
Hearing aids?	YES	NO	
Vision Evaluation	**Date**	**Place**	**Result**
Screening at school or doctor			
Opthamologist or Optometrist			
Glasses/Contacts?	YES	NO	

****If your child's hearing and/or vision has NOT YET been evaluated professionally, PDC recommends that these evaluations are completed as soon as possible.**

What skills do you believe would help your child succeed academically, socially, and at home? _____
_____
_____
_____
_____

Additional information you would like for PDC to know about your family or your child: _____
_____
_____
_____
_____

INSTRUCTIONS FOR THE INITIAL EVALUATION:

1. Complete this intake questionnaire in detail and return to The Pediatric Development Center. You may fax to 301-869-7515 or email to frontoffice@PDCandME.com.
2. Please email or bring with you all relevant prior medical and/or developmental reports from doctors, therapists, etc.
3. Our family outreach coordinator will contact you to schedule your child's initial appointment when completed forms are returned.
4. Please be sure to enter "Derwood" or "Silver Spring" as the city in your GPS to ensure you arrive on time.

Thank you. We look forward to meeting with you!