



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):

<input type="checkbox"/> Autism	<input type="checkbox"/> metabolic disorder	<input type="checkbox"/> ear infections
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> hypotonia	<input type="checkbox"/> concussion/head trauma
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> sensory disorder	<input type="checkbox"/> torticollis
<input type="checkbox"/> ADHD type: _____	<input type="checkbox"/> allergies	<input type="checkbox"/> reflux
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> frequent colds	<input type="checkbox"/> anxiety
<input type="checkbox"/> hospitalization	<input type="checkbox"/> surgery	<input type="checkbox"/> 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:

<input type="checkbox"/> audible breathing	<input type="checkbox"/> snores	<input type="checkbox"/> chronic congestion	<input type="checkbox"/> mouth often open
<input type="checkbox"/> mouth breathing	<input type="checkbox"/> enlarged tonsils	<input type="checkbox"/> sinus infections	<input type="checkbox"/> mouths objects/fingers/clothing
<input type="checkbox"/> ear infections	<input type="checkbox"/> enlarged adenoids	<input type="checkbox"/> asthma	other: _____

Description and Details (Respiration):

SLEEP:

<input type="checkbox"/> difficulty falling asleep	<input type="checkbox"/> wakes gasping	<input type="checkbox"/> mouth open	<input type="checkbox"/> sweats at night	<input type="checkbox"/> restless
<input type="checkbox"/> wakes frequently	<input type="checkbox"/> drools	<input type="checkbox"/> strange positions	<input type="checkbox"/> wets bed	<input type="checkbox"/> daytime drowsiness
<input type="checkbox"/> snoring	<input type="checkbox"/> night terrors	<input type="checkbox"/> holds breath	<input type="checkbox"/> tooth grinding	<input type="checkbox"/> does not sleep alone

Description and Other Observations:

BODY AWARENESS/SENSORY/ SELF-REGULATION:

<input type="checkbox"/> uncoordinated	<input type="checkbox"/> low energy	<input type="checkbox"/> aggression	<input type="checkbox"/> thumbsucking/oral habits
<input type="checkbox"/> floppy	<input type="checkbox"/> high energy	<input type="checkbox"/> difficulty with transitions	<input type="checkbox"/> difficulty with toilet training
<input type="checkbox"/> poor posture	<input type="checkbox"/> fidgets	<input type="checkbox"/> fears/dislikes noises	<input type="checkbox"/> difficulty in group situations
<input type="checkbox"/> easily distracted	<input type="checkbox"/> tantrums	<input type="checkbox"/> bothered by clothing/tactile media	<input type="checkbox"/> introvert

Description and Details:

FEEDING:

<input type="checkbox"/> difficulty nursing	<input type="checkbox"/> resistant to new foods	<input type="checkbox"/> tongue thrust	<input type="checkbox"/> diet restrictions; medically ordered
<input type="checkbox"/> picky eater	<input type="checkbox"/> coughs during meals	<input type="checkbox"/> constipation	<input type="checkbox"/> reflux
<input type="checkbox"/> food refusal	<input type="checkbox"/> often eats alone	<input type="checkbox"/> vomiting	<input type="checkbox"/> weight loss
<input type="checkbox"/> gags frequently	<input type="checkbox"/> often needs his own meal	<input type="checkbox"/> food allergies	<input type="checkbox"/> poor weight gain
<input type="checkbox"/> has choked	<input type="checkbox"/> must be fed	<input type="checkbox"/> food intolerance	<input type="checkbox"/> obese

Description and Details:

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

<input type="checkbox"/> normal pregnancy and birth	<input type="checkbox"/> surgery needed	<input type="checkbox"/> induced labor	<input type="checkbox"/> low APGARS
<input type="checkbox"/> bedrest ordered	<input type="checkbox"/> premature birth	<input type="checkbox"/> suction delivery	<input type="checkbox"/> jaundice
<input type="checkbox"/> medication taken	<input type="checkbox"/> multiples birth	<input type="checkbox"/> forceps delivery	<input type="checkbox"/> NICU
<input type="checkbox"/> placenta previa	<input type="checkbox"/> breech	<input type="checkbox"/> c-section delivery	<input type="checkbox"/> feeding tube
<input type="checkbox"/> preterm labor	<input type="checkbox"/> excessively long labor	<input type="checkbox"/> vaginal delivery	other:

Description and Details:

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

<input type="checkbox"/> eye contact	<input type="checkbox"/> sitting unsupported	<input type="checkbox"/> cooing	<input type="checkbox"/> shapes and/or colors
<input type="checkbox"/> sleeping all night	<input type="checkbox"/> crawling	<input type="checkbox"/> babbling	<input type="checkbox"/> ident/naming letters
<input type="checkbox"/> toilet training	<input type="checkbox"/> cruising	<input type="checkbox"/> use of gestures	<input type="checkbox"/> reading
<input type="checkbox"/> tummy time	<input type="checkbox"/> walking	<input type="checkbox"/> first words	<input type="checkbox"/> writing
<input type="checkbox"/> rolling	<input type="checkbox"/> pretend and/or peer play	<input type="checkbox"/> combining words	<input type="checkbox"/> 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			
Ophthalmologist 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!