JAMES L. DENNIS
DEVELOPMENTAL CENTER

UAMS
COLLEGE OF MEDICINE
DEPARTMENT OF PEDIATRICS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

REQUIRED INTAKE FORM FOR NEW PATIENTS

Child's Name:	Today's Date:
Child's Social Security #:	Child's Race:
Child's Date of Birth:	Sex: ☐ Male ☐ Female
Name of Person Completing this Form:	
Your Relation to the Child:	
Child's Address with City/State/Zip Code & County:	
Parent/Guardian Name(s):	**Best Daytime Phone Number:**
What is the PRIMARY language spoken in the home?	
Will parent(s) need an interpreter? ☐ Yes ☐ No	Will the patient need an interpreter? ☐ Yes ☐ No

What are your main concerns about your child's development, learning and/or behavior?

_____

_____

_____

How old was your child when you became concerned? _____

Please tell us what you hope to get from your child's appointment at our clinic:

_____

_____

_____

Does your child go to school or day care? ☐ Yes ☐ No Name of school/preschool: _____

Has your child ever been evaluated for special education services, developmental delays or learning problems? ☐ Yes ☐ No Date(s) of most recent evaluation: _____

Has your child EVER had any of the following tests or evaluations?

Hearing	☐ Yes ☐ No	__ Passed __ Failed
Vision	☐ Yes ☐ No	__ Passed __ Failed
Speech-Language Evaluation	☐ Yes ☐ No	Currently gets this therapy ☐ Yes ☐ No
Occupational Therapy Evaluation	☐ Yes ☐ No	Currently gets this therapy ☐ Yes ☐ No
Physical Therapy Evaluation	☐ Yes ☐ No	Currently gets this therapy ☐ Yes ☐ No

What has your child's teacher shared with you about your child? (Positive or negative)

_____

_____

Please list any current **medications** your child is taking for **sleep, behavior, mood or attention:** _____

_____

_____

Please list any chronic or recurrent medical conditions your child has (*Asthma, Cerebral Palsy, Seizures, Genetic Disorders, Cardiac Issues, etc…*):

_____

_____

Please list any previous developmental, behavioral or psychiatric diagnoses given to your child (*this includes diagnoses such as Speech-Language Delay, Autism, ADHD, Bipolar, Anxiety, etc…):*

_____

_____

Please check "yes" or "no" for each of the following questions and explain, as needed:

Does your child…	***(check)***	***(explain)***
Prefer to play alone?	o Yes o No	
Respond to his/her name?	o Yes o No	
Have unusual body movements (hand-flapping, toe-walking, etc.)?	o Yes o No	
Have poor eye contact?	o Yes o No	
Have any unusual fixations or obsessions?	o Yes o No	
See or hear things that are not there?	o Yes o No	
Frequently repeat other people or TV/movies?	o Yes o No	
Hit, slap, bite, pinch or injure themselves in any other way?	o Yes o No	
Make serious threats of self-harm?	o Yes o No	
Make serious threats to harm others?	o Yes o No	
Seem overly hyperactive or impulsive?	o Yes o No	
Have unusually aggressive behavior towards others?	o Yes o No	
Have a lot of trouble paying attention/focusing?	o Yes o No	
Currently under the treatment of a psychiatrist or counselor?	o Yes o No	

List any other information you feel might be helpful in determining the best type of evaluation or services for your child:

_____

_____

*****IMPORTANT TO READ*****

A scheduling decision or appointment will not be made until we receive this completed form. If you have trouble completing this form, please ask your child's PCP, teacher/therapist, case worker or other(s) for assistance. We need ***all*** of this information in order to properly address the needs of your child. Thank you for your time and effort spent completing this form.

_____ _____

Signature of Parent/Legal Guardian Date