THE UNIVERSITY OF CHICAGO
Section of Developmental and Behavioral Pediatrics
950 E. 61ST Street, SSC 207
Chicago, IL 60637
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Office Use Only
Date Received:

Date Reviewed:

INTAKE FORM
(must be COMPLETE prior to first visit)
CONFIDENTIAL AND PRIVILEGED INFORMATION
PLEASE PRINT ALL INFORMATION LEGIBLY

Name of person *completing form*: **Date *form completed*:**

Child's Name: _____
Birth Date: ____/___/_____Age:_____
Address: _____
_____
City: _____State: ___ ZIP: _____
Current School:_____
Grade Level: _____
Primary language(s) at home:
_____
Race/Ethnicity (optional):

What would you like answered or addressed by the evaluation?
_____
_____
_____
_____
_____
_____
_____

Parent 1
Name: _____
Birth Date: ____/___/_____Age:_____
Relationship to Child: _____
Occupation: _____
Address: _____
City: _____ State: ___ Zip:_____
Phone: (____) _____
Highest grade completed: _____
Best time to call:

Parent 2
Name: _____
Birth Date: ____/___/_____Age:_____
Relationship to Child: _____
Occupation: _____
Address: _____
City: _____State: ___ Zip: _____
Phone :(____) _____
Highest grade completed: _____
Best time to call:

Please complete only if not included above
GUARDIAN Name: _____ Age:___
Occupation: _____
Address: _____
City:_____ State: __ Zip:_____
Phone :(____) _____
How long have you known child? _____
Best time to call: _____

Any concerns in:	Yes/No	Age when noted:
How your child moves		
Fine Motor Skills		
Social Skills		
School Success		
Speech/Language		
Attention		
Feeding		
Sleep		
Behavior		

Primary Care Physician (PCP):
Name:_____
Address: _____
_____
Phone: _____
Fax: _____
Date child last seen: _____
***Before being scheduled with DBP*, this child MUST have been seen by PCP <u>within the last 6 months</u> REGARDING THIS CONCERN**

Milestone	Age
Walked	
Talked in single words	
Talked in short Sentences	
Sang a song	
Read simple words	
Did not need diapers during the day	
Did not need diapers at nigh	
Education Status	
IEP or Section 504 in place? (circle)	Yes/No
Does your child receive SSI? (circle)	Yes/No
Ever repeated a grade? (circle)	Yes/No
Number of suspensions/expulsions	#
Has your child ever received EI services or other therapies?	Yes/No
Ongoing therapies (with frequencies):	

Prior *Developmental* Evaluations	**Date**

Birth History
Birth weight:
Complications of pregnancy/birth:
Hospitalizations/Surgeries:

Previous Medical Diagnoses	**Date**

Current Medications	**Dose**

Past Medications	**Dose**

Comments:

Please list any hobbies or extracurricular activities that your child enjoys:

Name/type of Insurance:_____

If there is any additional information which you would like us to know or that may help us better understand your child, attach additional sheets, as needed.