

 Early Intervention Enrollment Packet

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Thank you for choosing Joya Child & Family Development to provide developmental evaluations and early intervention therapy services for your child. The enclosed questionnaire gives you a chance to tell us about your child. We want to know about your concerns and worries so that we can try to help. Knowing about things like your child’s health, past experiences, and family history can help us help your child.

The intake questionnaire should be completed by the person who takes care of your child most of the time. There is no right or wrong answer. Answer each question to the best of your ability. If you do not know the answer, make notes of what you do know.

We need this questionnaire before we can evaluate your child. It will be reviewed by staff at Joya Child & Family Development who will be involved in your child’s care. Please also let us know about any problems that were not covered on the forms.

If you have questions about the forms or have difficulty filling them out, please call our Family Resources Coordinators at **(509) 326-1651**.

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Please complete the following paperwork and return it to Joya in the enclosed postage paid envelope:

All information is kept strictly confidential.

[ ]  General Information Form and Enrollment Questionnaire

[ ]  Consent for Purposes of Treatment, Payment and Healthcare Operations

[ ]  Authorization for Release of Health Care Information

[ ]  Certificate of Immunization Status

[ ]  Spokane County ITN Referral Letter

[ ]  Early Support for Infants and Toddlers (ESIT) Consent to Access Insurance

NONDISCRIMINATION POLICY: Joya Child & Family Development is organized and shall be operated exclusively for educational purposes within the meaning of Section 501(c)(3) of the 1954 Internal Revenue Code. It shall not discriminate against members, prospective members, or their children on the basis of race, creed, sex, age, marital status or SSAN.

Revised **2019-05**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ [ ] M [ ] F

 (Last) (First) (M.I.)

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Person Completing Questionnaire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who will be the primary contact for your child?

Parent/Guardian #1 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone # for Parent/Guardian #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell Work Phone:

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian #2 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone # for Parent/Guardian #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell Work Phone:

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contacts (***other than parent/guardian***):

#1: Relationship to Child: Phone:

#2: Relationship to Child: Phone:

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Conditions (allergies, medications, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I give permission to Joya Child & Family Development personnel to authorize medical care, including surgery, if necessary, in case of illness or accident for the child listed above.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature Date

Is there a joint custody or parenting plan in effect? [ ]  Yes [ ]  No

Is there a restraining order in effect? [ ]  Yes [ ]  No

Is the restraining order against: [ ]  Mother [ ]  Father [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DCFS Caseworker (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION (please fill out ALL areas)**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I hereby authorize payment directly to Joya Child & Family Development for any benefits available under the insurance policy. Further, I request that benefits allowable under my major medical benefits be issued directly to Joya, should my contract prevent direct payment. I request that any draft to me be jointly payable to Joya.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature Date

**Today’s Date:**

**Who referred you to Joya?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your primary areas of concern/What are you hoping for the therapist to address?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child had previous therapy?** [ ]  No [ ]  Yes

If yes what type? [ ]  ST [ ]  PT [ ]  OT [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why did therapy stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child lives with: [ ]  Parent(s) [ ]  Guardian(s) [ ]  Foster Parent(s) [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s highest grade level or school completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s highest grade level or school completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other people living in the home:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Relationship to Child | Health Concerns/Learning Difficulties |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Does your child attend daycare? [ ]  No [ ]  Yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Days and times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there someone else who regularly watches your child? [ ]  No [ ]  Yes, where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Days and times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wakes for the day at: \_\_\_\_\_\_\_am Nap #1: \_\_\_\_\_ to \_\_\_\_\_ Nap #2: \_\_\_\_\_ to \_\_\_\_\_ Bedtime: \_\_\_\_\_pm

Best days & times for therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Communication

What is your child’s primary mode of communication? (Gestures, signing, single words, short phrases, sentences, picture exchange, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child get his/her needs met? (Pointing, grunting, taking item to you, requesting verbally, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give an estimate of how many words are in your child’s vocabulary:

 Receptive (words your child understands): \_\_\_\_\_\_\_ Expressive (words your child speaks): \_\_\_\_\_\_\_

How much of your child’s speech do **you** understand?

 [ ]  10% or less [ ]  11-24% [ ]  25-50% [ ]  51-74% [ ]  75-100% [ ]  N/A

How much of your child’s speech do **others** understand?

 [ ]  10% or less [ ]  11-24% [ ]  25-50% [ ]  51-74% [ ]  75-100% [ ]  N/A

Does your child demonstrate frustration when he/she is not understood? [ ]  No [ ]  Yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child pass their newborn hearing screen (in the hospital)? [ ]  No [ ]  Yes

Has your child’s hearing been checked recently? [ ]  No [ ]  Yes, result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, where was your child’s hearing checked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns with hearing? [ ]  No [ ]  Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been diagnosed or treated for the following? If yes, please describe:

**No Yes**

[ ]  [ ]  Tongue tie: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Lip tie: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Cheek tie: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nutrition/Feeding

Which type(s) of **milk** does your child drink? [ ]  Breastmilk [ ]  Formula [ ]  Cow milk [ ]  Other: \_\_\_\_\_\_\_\_\_\_

 At what times does your child nurse/take a bottle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N/A

 How long does your child take to complete a feed? Nursing: \_\_\_\_\_\_min. Bottle: \_\_\_\_\_\_min. \_\_\_\_\_\_oz.

 Bottle system: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nipple size: \_\_\_\_\_\_\_ If formula, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child receive nutrition? Check all that apply:

[ ]  Breast [ ]  Sippy cup [ ]  Straw [ ]  Spoon [ ]  Fork [ ]  NG-Tube [ ]  G-Tube

[ ]  Bottle [ ]  Open cup [ ]  Hand [ ]  NJ-Tube [ ]  GJ-Tube

Where does your child eat their meals? [ ]  High chair [ ]  Table [ ]  No structured seating [ ]  N/A

Circle what times your child eats at during the day (other than milk or formula):

12mid 1 2 3 4 5 6 7 8 9 10 11 12noon 1 2 3 4 5 6 7 8 9 10 11

What other liquids does your child drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Daily volume: \_\_\_\_\_\_\_ oz./24 hours

Foods your child likes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N/A

Foods your child dislikes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N/A

Does your child have any of the following with feeding? If yes, please describe below:

[ ]  Difficulty latching [ ]  Tiring [ ]  Gagging [ ]  Coughing/Sputtering [ ]  Texture Sensitivities

[ ]  Overstuffs mouth [ ]  Picky [ ]  Arching [ ]  Retching [ ]  Pockets food in cheeks [ ]  N/A

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a picky eater, why? (few foods, texture, small amounts): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any of the following GI concerns? If yes, please describe below:

[ ]  Spitting up [ ]  Reflux [ ]  Constipation [ ]  Abnormal stool [ ]  Diarrhea [ ]  N/A

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does your child have bowel movements? # \_\_\_\_\_ every \_\_\_\_\_ day(s) Consistency: \_\_\_\_\_\_\_\_\_\_\_\_

 Difficulty w/bowel movements? [ ]  No [ ]  Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child see a Registered Dietician? [ ]  No [ ]  Yes, whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in a consultation with a Registered Dietician? [ ]  Yes [ ]  No

Gross & Fine Motor/Behavior/Social

**Please fill in the blanks to describe your child to the best of your ability:**

Sat at \_\_\_\_\_\_\_\_\_\_ months/years Fed self at \_\_\_\_\_\_\_\_\_\_ months/years

Crawled at \_\_\_\_\_\_\_\_\_\_ months/years First single words at \_\_\_\_\_\_\_\_\_\_ months/years

Stood at \_\_\_\_\_\_\_\_\_\_ months/years Put words together at \_\_\_\_\_\_\_\_\_\_ months/years

Walked at \_\_\_\_\_\_\_\_\_\_ months/years Making sentences at \_\_\_\_\_\_\_\_\_\_ months/years

Ran at \_\_\_\_\_\_\_\_\_\_ months/years

**Please list any other motor development concerns you have** (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the boxes that best describe your child (check all that apply):**

[ ]  Was placed on his/her belly as an infant [ ]  Was not placed on his/her belly as an infant

[ ]  Enjoyed tummy time as an infant [ ]  Did not tolerate being placed on his/her tummy as an infant

[ ]  Met all motor milestones on time [ ]  Was late to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Is good at negotiating playground equip. [ ]  Is clumsy

[ ]  Is good with his/her hands (fine motor) [ ]  Avoids climbing, swinging, sliding

[ ]  Is social and engaging [ ] Is aggressive

[ ]  Makes good eye contact w/aduts/peers [ ]  Is oppositional

[ ]  Is well behaved [ ]  Does not like new places/people

[ ]  Pays attention [ ]  Does not like crowds

[ ]  Listens well [ ]  Has difficulty with transitions

[ ]  Follows directions well [ ]  Prefers to play alone

[ ]  Has difficulty paying attention [ ]  Is very busy and active

[ ]  Plays well with other children [ ]  Has difficulty listening

[ ]  Is easy going [ ]  Has poor coping skills

[ ]  Does well with change [ ]  Unable to self-calm

[ ]  Understands safety [ ]  Quickly escalates without apparent cause

[ ]  Takes turns with peers [ ]  Has tantrums

**Please list any behavior or social concerns:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancy History

**Prenatal Care:** [ ]  No [ ]  Yes, beginning at (weeks gestation): \_\_\_\_\_\_ wks

# Pregnancies \_\_\_\_\_ # Live Births \_\_\_\_\_ # Still Births \_\_\_\_\_ # Miscarriages \_\_\_\_\_ # Terminations \_\_\_\_\_

**Did the mother have any of the following during pregnancy? Please explain if checking “yes”.**

**No Yes**

[ ]  [ ]  Fever or rash: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Sugar in urine/diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Anemia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Group B strep positive? Did the mother receive adequate antibiotics prior to delivery? [ ]  Yes [ ]  No

[ ]  [ ]  Bedrest? During which weeks of pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Tobacco use, Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Alcohol use, Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Marijuana use, Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Recreational drug use, List drug and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Medication use (prescription or over-the-counter)? List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Depression or anxiety during or following the birth of the child (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any other significant prenatal history:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Newborn History

Birth weight: \_\_\_\_\_\_lbs. \_\_\_\_\_\_ oz. Birth length: \_\_\_\_\_\_ in. Head circumference: \_\_\_\_\_\_ in.

Estimated due date:

Gestational age at delivery: \_\_\_\_\_\_\_ wks. \_\_\_\_\_\_\_ days [ ]  Apgars: , ,

[ ]  Vaginal delivery [ ]  Vacuum delivery [ ]  Forceps delivery

[ ]  C-section, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Breech

How old was your baby when he/she left the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your baby admitted to the NICU? [ ]  No [ ]  Yes, length of stay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your baby have newborn screens (PKU)? **At 1 day old**: [ ]  Yes [ ]  No **At 2 weeks old**: [ ]  Yes [ ]  No

**Did your child have any of the following during the first week of life? Please explain if checking “yes”.**

**No Yes**

[ ]  [ ]  Seizures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Fever: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Cyanosis (blueness): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Breathing trouble: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Require oxygen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Ventilator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Feeding trouble: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Excess vomiting/reflux? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Diarrhea: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Receive antibiotics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Jaundice (yellow skin): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  [ ]  Phototherapy (bili lights): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any other significant newborn history:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Health History

**Does your child have (or have they ever had) any of the following? Please explain if checking “yes”.**

**No Yes**

[ ]  [ ]  Frequent ear infections/hearing concerns:

[ ]  [ ]  Problems with eyes/vision:

[ ]  [ ]  Lung/breathing problems:

[ ]  [ ]  Heart problem/murmur:

[ ]  [ ]  Anemia/bleeding problem:

[ ]  [ ]  Abdominal problem/constipation:

[ ]  [ ]  Bladder or kidney problem/infections:

[ ]  [ ]  Chronic/recurrent skin problems:

[ ]  [ ]  Seizures/neurological problems:

[ ]  [ ]  Thyroid/endocrine problems:

[ ]  [ ]  Sleep issues:

[ ]  [ ]  Behavior concerns:

[ ]  [ ]  Hospitalization(s):

**Is your child immunized?\*** [ ]  No [ ]  Yes [ ]  Yes, *with exemptions*:

 **\****Please note, children must be fully immunized to participate in toddler & preschool group.*

**Does your child see a dentist?** [ ]  No [ ]  Yes, child’s age at first visit:

Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:

**Has your child seen an ophthalmologist?** [ ]  No [ ]  Yes, ophthalmologist:

**Has your child seen an audiologist?** [ ]  No [ ]  Yes, audiologist:

**Please list any other significant health history:**

Child’s Health History (cont.)

**Please list any medications your child takes (including over the counter, herbs, and supplements):** [ ]  None

|  |  |  |
| --- | --- | --- |
| Name | Dose | How often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list any medical procedures, tests or surgeries your child has had:** [ ]  None

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Procedure/test/surgery | Where | When | Age | Result |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please list any allergies to medications or foods:** [ ]  None

|  |  |
| --- | --- |
| Medication/Food | Symptom/Reaction |
|  |  |
|  |  |
|  |  |
|  |  |

**Please list any family history of birth defects, chronic illness, developmental delays, learning difficulties, problems with attention or focus, social difficulties, problems with speech or motor development, etc:**

|  |  |  |
| --- | --- | --- |
| **FAMILY MEMBER** | **HISTORY OF ANYTHING LISTED ABOVE OR OTHER HEALTH CONCERNS**  |  |
| Father |  | [ ]  None |
| Father’s father |  | [ ]  None |
| Father’s mother |  | [ ]  None |
| Father’s sibling(s) |  | [ ]  None |
| Mother |  | [ ]  None |
| Mother’s father |  | [ ]  None |
| Mother’s mother |  | [ ]  None |
| Mother’s sibling(s) |  | [ ]  None |
| Child’s sibling |  | [ ]  None |
| Child’s sibling |  | [ ]  None |
| Other: |  | [ ]  None |

One goal of Joya is to educate the public about the services we provide to children and their families. To that end, Joya may wish to use photographs and videos of children on our website, social media channels, and in educational publications and marketing materials (both internet and print).

I, , hereby authorize Joya Child & Family Development (“Joya”) to engage in the following specific activities that may involve my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s, personal health information. I recognize that I have the right to deny Joya the ability to use my child’s personal health information in the manners described below.

I understand that I have the ability to revoke this authorization by providing Joya with a written revocation unless Joya has already disclosed my child’s personal health information for the purposes described below relying upon this Authorization. A written revocation should be sent to Joya Child & Family Development, Attention: Dana Mundy, 2118 W. Garland, Spokane, WA 99205.

This Authorization shall expire three (3) years from the date of signature. I further understand that Joya will not condition its providing treatment to me based on my execution of this Authorization or any part hereof and that my participation is voluntary.

1. **Photo Permission**

[ ]   **Yes**, I give permission for **my child’s picture to be taken** and used in connection with any publicity for

 Joya. I understand that no royalty, fee or other compensation shall become payable to me by reason of

 such use. **Initials \_\_ \_\_.**

 [ ]   **No,** I do not wish for Joya to take my child’s picture. **Initials \_\_ \_\_.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature Date

**Please check which resource(s) your family is currently receiving:**

[ ]  WIC (Women, Infants & Children) [ ]  Food Stamps (EBT)

[ ]  TANF (Temporary Assistance for Needy Families) [ ]  SSI (Supplemental Security Income)

[ ]  Counseling [ ]  Visiting Nurse

[ ]  Housing Assistance [ ]  Head Start/Early Head Start

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  None

**Are there areas where you could use additional help?**

[ ]  Transportation [ ]  Growth/Nutrition [ ]  Medical/Healthcare [ ]  Counseling

[ ]  Food [ ]  Parent/Child development [ ]  Hearing/Audiology [ ]  Clothing

[ ]  Housing [ ]  Special Equipment [ ]  Vision/Ophthalmologist [ ]  Parent Support

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  None

**Would you like more information about Circle of Security Parenting classes?** [ ]  Yes [ ]  No

**Would your family be interested in being contacted about participating in fundraising activities with the**

**Joya Development Office?** [ ]  Yes [ ]  No

**\*\*For Office Use Only\*\***

Intake Packet Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Resources Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Entrance COS Needed? [ ]  Yes [ ]  No, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatric Evaluation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  TBD After Beginning Therapy

FRC notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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