Interdisciplinary Assessment Intake Form

Today's Date _____

Client Name: _____ Nickname: _____

Client's Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved in Care:

Physician/Specialist: _____ Phone Number _____

Address: _____

Physician/Specialist: _____ Phone Number _____

Address: _____

Physician/Specialist: _____ Phone Number _____

Address: _____

Family Background

Parent/Caregiver 1 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Parent/Caregiver 2 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Which adult(s) does the child live with? Check all that apply:

☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)

☐Grandparent(s) ☐Both Parents ☐Parent 1 Only

☐Parent 2 Only ☐Other: _____

Does the child have siblings or are there other siblings in the home?

Child 1 Name: _____ Age: ___

Child 2 Name: _____ Age: ___

Child 3 Name: _____ Age: ___

Describe any developmental/medical concerns with sibling(s):_____

_____

Primary language spoken in the home:_____

Other language(s) spoken in the home: _____

Who speaks the other language(s)? _____

Describe the client's use/understanding of the language(s): _____

_____

Referral for Services

Has the client had (a) previous evaluation(s) / treatment? ☐Yes ☐No By whom:

_____ When: _____

Describe the results: _____

_____

_____

Briefly describe why you are seeking an assessment at this time:

_____

_____

_____

_____

At what age did you first notice the problem(s)? _____

THE CENTER FOR CONNECTION
CONNECT. GROW. THRIVE.

Medical History

Biological Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐Yes ☐No

Describe: _____

2. Were there any complications during the pregnancy? ☐Yes ☐No

Describe: _____

3. Were there any maternal complications during labor or delivery? ☐Yes ☐No

Describe: _____

4. What was the biological mother's age at the time of delivery? _____ years

Client's Health:

1. How many weeks gestation was the client born? _____ weeks (40 weeks is typical)
2. The client was _____ lbs ____oz and _____ inches at birth
3. How was the client delivered? ☐ Vaginally ☐ Cesarean Section
4. Please describe any complications or concerns with the baby during labor or delivery:

_____

_____

_____

5. Please describe any previous/current illnesses, medical complications, or health concerns:

_____

_____

_____

Is the client up to date with immunizations: ☐ Yes ☐ No

If not, please describe: _____

Has the client ever had surgery? ☐ Yes ☐ No

Please describe: _____

_____

Has the client ever been hospitalized: ☐ Yes ☐ No

Please describe: _____

_____

Has the client ever been in a serious accident? ☐ Yes ☐ No

Please describe: _____

_____

Is the client currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Medication 5: _____

Does the client have any known allergies? ☐ Yes ☐ No

Describe: _____

_____

Does the client currently use any supportive equipment? (e.g., communication device, walker, etc.) Describe:

_____

_____

Date of the client's most recent hearing evaluation/exam: _____

Were there any concerns? ☐Yes ☐No

Describe:_____

Does the client have a history of hearing loss, ear infections, tubes, etc. or use hearing aides?

☐Yes ☐No Describe:_____

_____

Service History

Is the client currently receiving any of the following services? If yes, please list the person's name, frequency of service(s), and length of service(s).

☐ Developmental Pediatrician _____

☐ Neurologist _____

☐ PT _____

☐ OT _____

☐ SLP _____

☐ Behavioral Therapist _____

☐ Educational Consultant _____

☐ Psychologist / Psychiatrist _____

☐ Vision Therapist _____

☐ Other: _____

Developmental History

At what age did the client do the following:

Sit alone: _____ Crawl: _____

Stand Up: _____ Walk: _____

Make Sounds: _____ First Word: _____

Combine Words: _____ Sentences: _____

Feed Self: _____ Understood by Others_____

Toilet Trained: _____ Dress Self: _____

If the client has a limited vocabulary, how many words does the child say:

☐0-20 ☐21-50 ☐51-100 ☐101-150 ☐151-300 ☐301-500 ☐501+

Does the client produce sentences of the following length:

☐2 words ☐3 words ☐4 words ☐5+ words

What percentage of the client's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

Has the client experienced any difficulty with feeding or swallowing? If so, please describe:

_____

_____

Educational History

Name of the client's current school/program? _____

What day(s)/hours do they attend? _____

What is their grade level: _____

Type of classroom: _____

Do they have an IEP: ___Yes ___No 504 Plan: ___Yes ___No

If they receive any accommodations/modifications, please describe:

_____

_____

_____

Please describe any educational difficulties or learning challenges that this client has faced:

_____

_____

_____

_____

Person filling out the form: _____

Relationship to the client: _____

Signature:_____