GMA INTAKE

Date: _____

Name: _____

Date of birth: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Phone: _____ Cell Phone: _____

Person completing form: _____ Relationship to child: _____

MEDICAL HISTORY:

How long was the pregnancy? ☐ Full Term ☐ Other *(specify):* _____

Were there any prenatal or postnatal complications? ☐ Yes ☐ No If Yes, please specify: _____

_____

Were there any problems during delivery? ☐ Yes ☐ No If Yes, please explain: _____

_____

Did the baby have any medical problems after birth? ☐ Yes ☐ No If Yes, please explain: _____

_____

Is the child growing well? ☐ Yes ☐ No If No, please explain: _____

Are immunizations up-to-date? ☐ Yes ☐ No If No, please explain: _____

Allergies? ☐ Yes ☐ No If Yes, please specify: _____

Frequent ear infections? ☐ Yes ☐ No If Yes, please specify: _____

Seizures? ☐ Yes ☐ No If Yes, please specify: _____

Please list any hospital admissions or emergency room visits for your child:

Date	Hospital	Reason

Please list any medications your child takes on a regular basis:_____

_____

_____

Has your child's hearing and vision ever been checked? ☐ Yes ☐ No

If Yes, where and what were the results:_____

_____

Were the following milestones met within normal limits? ☐ Yes ☐ No If no, please specify:

Walking: _____

First Words:_____

Sentences: _____

Toilet Training: Day_____Night _____

EDUCATIONAL HISTORY:

Please list all schools or early intervention programs your child has attended:

Year	Age	Schools / Early Intervention Programs	Grade / Type of Service

Does your child have difficulties in school or receive any tutoring or extra support? ☐ Yes ☐ No

If Yes, please explain: _____

_____

Has your child had any previous evaluations conducted/diagnoses offered? ☐ Yes ☐ No

If Yes, please explain: _____

_____

BEHAVIORAL HISTORY:

How does your child get along with other children? _____

What does your child like to do for play?_____

_____

FAMILY HISTORY:

	Name	Age	Highest Grade level	Occupation
Father				
Mother				

	Name	Age	Gender	Any Developmental concerns?
Sibling				
Sibling				
Sibling				

Is English the child's primary language? ☐ Yes ☐ No

Is a second language spoken at home? ☐ Yes ☐ No If Yes, please specify: _____

The following MUST be signed:

My signature below indicates that I have read and understood the office policies of Childhood Solutions, PC.

I also understand that failure to pay for any services rendered can result in legal action.

I give my consent for Childhood Solutions, PC to evaluate and/or treat my child who is under 14 years of age.

Signature: _____

Relationship to patient: _____ Date: _____

Any information included on this form may be included in the report when being shared with my doctor or school.

Please tell us anything else you think is important for us to know: _____

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