UNM CENTER FOR Development and Disability
UNM Medical Group, Inc.

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Albuquerque, NM 87107
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http://www.cdd.unm.edu/

Child Information

Please complete all sections

INTAKE INFORMATION

Who is completing this form? _____ Today's date: _____
Name and relationship to child

Who is referring? _____ Referrer's phone: _____
Name and relationship to child

CHILD'S INFORMATION

Name:_____ Date of birth: _____

Sex: M F

Primary language: _____ Other languages: _____

PEDIATRICIAN / PRIMARY CARE PROVIDER

Name: _____

Phone: _____ Fax: _____

Address: _____

PARENTS/CAREGIVERS

Are the Parents the legal guardians for this child? □ *Yes* □ *No*

1. Name: _____ 2. Name: _____

Relationship: _____ Relationship: _____

Email address: _____ Email address: _____

Mailing address: _____ Mailing address: _____

_____ _____

Phones: _____/_____ Phones: _____/_____
Primary *Other* *Primary* *Other*

Legal Guardians, Foster Parents or Other Caregivers:

1. Name: _____ 2. Name: _____

Relationship: _____ Relationship: _____

Email address: _____ Email address: _____

Mailing address: _____ Mailing address: _____

_____ _____

Phones: _____/_____ Phones: _____/_____
Primary *Other* *Primary* *Other*

Is the Children, Youth and Families Department (CYFD), or other protective service agency, involved with the child or family? □ *Yes* □ *No*

If yes, please provide the CYFD Social Worker or contact:

Name: _____ Phone: _____ Email: _____ Fax: _____

Who lives in the home with the child?

Name	Age	Relationship to Child	Primary Language
1.			
2.			
3.			
4.			
5.			
6.			

If English is not the native language for yourself or your child, will an interpreter be needed for the evaluation?

□ *Yes* □ *No* *If yes, what language?* _____

SERVICE PROVIDER INFORMATION

Is the child currently in intervention services? *(For example: early intervention, school, other therapy services, etc.)*

□ *Yes* □ *No*

Please provide the following information regarding current intervention services:

Therapist	Name	Agency/School	Phone
Developmental Specialist			
Speech Language Pathologist			
Occupational Therapist			
Physical Therapist			
Social Worker/Counselor			
Hearing Specialist			
Special Education			
Vision Specialist			
Other:			
Other:			

CONCERNS / QUESTIONS

Check all boxes below that best describe the nature of your concern(s):

□ Accidents / Injuries
□ Allergies
□ Asthma
□ Attention
□ Autism Spectrum Disorder
□ Behavioral Difficulties
□ Coordination / Balance
□ Ear Infections
□ Epilepsy / Seizures
□ Family Stressors
□ Feeding / Nutrition
□ Hearing
□ Learning / Thinking
□ Medical / Health
□ Motor (Use of arms/legs)
□ Premature / Complex Birth
□ Prenatal Exposures
□ Sensory / Regulation
□ Sleep
□ Special Equipment
□ Speech / Language
□ Vision
□ Other: _____
□ Other: _____

Child's Name: _____ *MRN:*_____

Please explain your concerns or questions: _____

_____

_____

What do you hope to gain from this evaluation? _____

_____

_____

What does the child do well? _____

_____

What activities does the child enjoy? _____

_____

_____

MEDICAL/DEVELOPMENTAL INFORMATION

Has the child had a vision screening? □ *Yes* □ *No*

Has the child had a hearing screening? □ *Yes* □ *No*

Does the child have medical, behavioral, and/or developmental diagnoses? *(For example: Fragile X, ADHD, seizure disorder, Autism Spectrum Disorder, etc.):* □ *Yes* □ *No*
If yes, please list: _____

_____

Does the child take medication? □ *Yes* □ *No*
If yes, please list: _____

_____

When did the child first do the following:

	Age	**Not Yet**	**Not Sure**
Rolled over			
Sat without help			
Crawled on hands and knees			
Walked without help			
Said single words			
Put two or more words together (e.g., “green car”)			
Talked in short sentences (e.g., “Daddy has a green car”)			
Toilet trained (during the day)			
Toilet trained (overnight)			

Did the child ever lose any of the above skills? □ *Yes* □ *No*
If yes, please describe: _____

_____

Please feel free to attach any additional information that you would like to provide.