INITIAL INTAKE FORM

ROCHESTER REGIONAL HEALTH	**Developmental-Behavioral Pediatrics Program** **Rochester General Hospital** Wilson Medical Building, 2nd Floor, Suite 260 800 Carter Street Rochester, NY 14621 **Phone** (585) 922-4698 **Fax** (585) 922-5702

The Developmental-Behavioral Pediatrics Program is a multi-disciplinary practice specializing in the evaluation, diagnosis, and treatment of children and adolescents with developmental and behavioral disorders. For more information about our services, including the types of conditions we evaluate and treat, please visit http://www.rochestergeneral.org/dbp

Initial intake process

Please note, the below intake form is used as a screen to determine if our clinic can meet the needs of your child.
-If your child has been accepted for an evaluation, there will be additional paperwork for the family and school to complete.
-Administration of standardized testing through the school district (if not recently done) will be required for all evaluations with a Developmental Pediatrician, though may not be required for counseling-only visits. The testing process can take an extended amount of time and can delay an evaluation in our clinic.
-Based upon review of this intake form, we will notify you if testing is required.
-Your appointment will be scheduled once we have received **all** required paperwork.
-If it is determined that your child's needs are best served elsewhere, we will try to direct you towards appropriate resources.

Items required as part of the initial intake process:
☐ Completed initial intake form
☐ Referral from the child's primary care doctor (form available on our website)
☐ Copies of previously completed evaluations, standardized testing, and school plans (as indicated throughout the intake form)
☐ Family must verify with child's health insurance carrier that services in our clinic are covered (including billing code 96111). The family will be responsible for costs if the child's insurance does not cover visits.

Instructions: Please complete form in full and return to the above address or fax number. **Incomplete forms will be returned for completion, leading to a delay in processing. If you need help completing the form, please contact our office.**

Once we have received your completed intake form, we will notify you of receipt within 5 **business days** via your automated message preference selection below. If you have not heard from us by that time, please contact us at 585-922-4692.

RGH Developmental-Behavioral Pediatrics Intake Form

Date	M	M	/	D	D	/	Y	Y	Y	Y

Person Completing Form:		**Relationship to child:**	
Child's Legal Name:		**Child's Age:**	
Child's Date of Birth:	M M / D D / Y Y Y Y	**Gender:**	
Child's Address:	STREET ADDRESS, CITY, STATE, ZIP CODE		
Preferred Language:	☐English ☐Spanish ☐Other:	Interpreter needed? ☐Yes ☐No	
Automated Message Preference (**check one**):	☐ Text: ( ) CELL	☐ Phone: ( ) CELL or HOME	
	☐ Email: EMAIL		
Are there any custody issues or orders of protection of which we should be aware? ☐Yes* ☐No *If yes, describe:			
Legal Guardian(s):	☐Mother ☐Father	☐Other: SPECIFY	
Parent/Caregiver 1 Full Name:	FIRST NAME	Relationship to child:	
	LAST NAME	Legal guardian?:	☐Yes ☐No
Home Address:	IF DIFFERENT FROM CHILD'S ADDRESS ABOVE		
Mailing Address:	IF DIFFERENT FROM HOME ADDRESS		
Phone (**check preferred**):	☐ ( ) HOME	☐ ( ) WORK	☐ ( ) CELL
Parent/Caregiver 2 Full Name:	FIRST NAME	Relationship to child:	
	LAST NAME	Legal guardian?:	☐Yes ☐No
Home Address:	IF DIFFERENT FROM CHILD'S ADDRESS ABOVE		
Phone (check preferred):	☐ ( ) HOME	☐ ( ) WORK	☐ ( ) CELL
Parents' Marital Status	☐Married ☐Divorced ☐Separated ☐Never Married ☐Widowed		
Child's Caregivers:	☐Biological ☐Adoptive ☐Foster ☐Other:		
Primary Doctor:		Telephone:	( )
Primary Insurance:			
Employer:			
Address:		Telephone:	( )
Subscriber Name:		Subscriber Date of Birth:	M M D D Y Y Y Y
Group Number:		Policy Number:	
Secondary Insurance:			
Employer:			
Address:		Telephone:	( )
Subscriber Name:		Subscriber Date of Birth:	M M D D Y Y Y Y
Group Number:		Policy Number:	

Child's Name: ________________________________DOB: ______________

Reasons for Visit					
Who initially referred you to our clinic for an evaluation? ☐Primary Doctor ☐Psychologist/counselor ☐School ☐Other: SPECIFY					
Reason for referral (please be as specific as possible):					
Have you spoken with your child's primary doctor about your concerns?:				☐Yes	☐No
(A referral from your child's primary doctor will be required for an evaluation in our clinic)					
Were you referred to a specific provider in our practice? (indicate below)				☐Yes	☐No
Developmental Pediatrician		Psychologists			
☐	Jara Johnson, DO MPH	☐	Scott Anderson, PhD	☐	Roger Yeager, PhD
		☐	Jessica Moore, PhD		

Parental Concerns	
What are your top 3 concerns regarding your child?	
1.	
2.	
3.	

School Concerns		
Does the school have any concerns regarding your child (*if yes, describe):	☐Yes*	☐No

Treatment Goals:		
Are you seeking an evaluation/diagnostic services?	☐Yes	☐No
Are you seeking counseling/therapy?	☐Yes	☐No
Are you seeking medication consultation and/or management?*	☐Yes	☐No
*The child's doctor must complete the current/past medications section on referral form		
Are you seeking a second opinion?	☐Yes*	☐No
*If yes, we will need a copy of the initial assessment		
Is there anything outside of the above that you are hoping to get from your visits with our clinic?:		

Child's Name: ________________________________DOB: ______________

Specific Concerns			
Our practice provides a variety of services. In order to best assess if we can meet your needs, please help us understand your specific concerns.			
Are you concerned about any of the following?:	**Yes**	**No**	**Please describe**
Anxiety	☐	☐	
Attentional difficulties	☐	☐	
Behavioral challenges	☐	☐	
Hyperactivity or impulsivity	☐	☐	
Learning difficulties	☐	☐	
Moodiness or irritability	☐	☐	
School problems	☐	☐	
Situational stressors	☐	☐	
Sleep disturbances	☐	☐	
Social difficulties	☐	☐	
Tics	☐	☐	
Toilet training difficulties	☐	☐	
Other (specify):	☐	☐	

Developmental-Behavioral Diagnoses					
Has your child ever been diagnosed with any of the following? If there are concerns, though child not diagnosed, please check 'Concerns':	**Yes**	**No**	**Concerns, though not diagnosed**	**Date diagnosed**	**By Whom?**
Anxiety disorder	☐	☐	☐		
Attention Deficit/Hyperactivity Disorder	☐	☐	☐		
Autism Spectrum Disorder (includes Autistic Disorder/Autism, Asperger Syndrome, Pervasive Developmental Disorder- Not Otherwise Specified)	☐	☐	☐		
Bipolar Disorder	☐	☐	☐		
Depression	☐	☐	☐		
Developmental Delay	☐	☐	☐		
Intellectual Disability (previously Mental Retardation)	☐	☐	☐		
Language Disorder	☐	☐	☐		
Learning Disability	☐	☐	☐		
Mood Disorder	☐	☐	☐		
Obsessive-Compulsive Disorder	☐	☐	☐		
Oppositional Defiant Disorder	☐	☐	☐		
Other (specify):	☐	☐	☐		

Child's Name: ________________________________DOB: ______________

Medication History				
Does your child take medications for *inattention, anxiety, behavior, mood, sleep?*			☐Yes*	☐No
*Please list **all medications** your child **currently takes** *for inattention, anxiety, behavior, mood, sleep*:				
Name of medication	**Reason for taking**	**Dosage**	**Frequency**	**Period taken**
Who is prescribing the above medication(s)?:				
Has your child **previously** taken medications for these concerns?			☐Yes*	☐No
*Please list **all medications** your child **has previously taken** *for inattention, anxiety, behavior, mood, sleep*:				
Name of medication	**Reason for discontinuation**	**Dosage**	**Frequency**	**Period taken**

Medical History		
Does your child have any medical/physical diagnoses or problems?	☐Yes*	☐No
*If yes, please specify:		
Are the child's immunizations up-to-date as per the childhood vaccination schedule recommended by the CDC?	☐Yes	☐No*
*If no, please explain:		

Professional Evaluations					
Has your child previously been evaluated by any of the following providers? (please check all that apply and provide copies of reports)					
	Previous evaluations		Provider name	Evaluation date	Diagnosis
Developmental Pediatrician	☐Yes	☐No			
Neurologist	☐Yes	☐No			
Psychiatrist	☐Yes	☐No			
Psychologist	☐Yes	☐No			
Other:________________	☐Yes	☐No			

Counseling Services		
Is your child currently receiving or has your child previously received counseling services – either privately or through the school district?	☐Yes*	☐No
*If yes**,** indicate name of therapist & dates seen:		

Child's Name: ________________________________ DOB: ______________

Preschool/School Information:			
Does your child currently attend preschool/school? ***If yes**, complete below.		☐ Yes*	☐ No
Current Preschool/School:			
School District:			
School Address:			
Contact Numbers:	*PHONE*	*FAX*	
Grade Level:			
Teacher Name(s):			
Classroom Setting:	☐ Regular ☐ Co-taught ☐ Blended/integrated ☐ 15:1:1 ☐ 12:1:1 ☐ 8:1:1 ☐ 6:1:1		

Has your child been evaluated by any of the following?:			Age at evaluation
Early Intervention (EI)	☐ Yes*	☐ No	(birth thru age 2)
Committee on Preschool Special Education (CPSE)	☐ Yes*	☐ No	(ages 3 & 4)
Committee on Special Education (CSE)	☐ Yes*	☐ No	(ages 5+)

***If yes**, please check all areas assessed and **provide copies of testing reports**:

☐ IQ ☐ Achievement ☐ Speech/Language ☐ Fine motor ☐ Gross motor

Does your child currently receive any support services in school or privately?	☐ Yes*	☐ No

***If yes**, please check all the services that your child receives (denote if received privately):

☐	1:1 aide	☐	Physical Therapy
☐	Academic Intervention Service (AIS)	☐	Resource Room
☐	Accommodations (test time, seating, scribe, etc.)	☐	Response to Intervention (RtI)
☐	Consultant Teacher	☐	Speech Therapy
☐	Counseling	☐	Tutor
☐	Interpreter	☐	Other (specify):
☐	Occupational Therapy		

Does your child have any of the following plans in school?:			☐ Yes*	☐ No
☐ 504 Plan	☐ IEP	☐ Behavior Intervention Plan	***If yes, please provide copies**	

Comments		
Is there anything additional you would like us to know about your child?	☐ Yes	☐ No

Child's Name: ________________________________DOB: ______________

Attestation
Are all of the child's legal guardians aware this evaluation is being pursued with the opportunity to participate in the process? ☐ Yes ☐No If no, explain:
I certify that the information throughout this form is to the best of my knowledge and belief, true, correct, and complete. I understand that it is my responsibility to keep up-to-date contact information with this office. I hereby authorize medical evaluation & treatment, as well as release of information for insurance/medical purposes concerning the condition and treatment. I authorize payment from my insurance company to the Rochester Regional Health System for services rendered. I understand that payment is expected at the time of service, unless I have made prior arrangements. I agree to pay all fees that incur from any visits to this office that my insurance does not cover. I understand that failure to do so will result in being sent to the collections department. I also understand that missed appointments, or appointments cancelled without 24 hours notice, are subject to a charge of $45.00 _______________________________ Parent/Guardian Signature   _______________ Date

Please mail completed form to:

Developmental-Behavioral Pediatrics Program
Rochester General Hospital
800 Carter Street, Suite 260
Rochester, NY 14621