Ochsner Hospital For Children

Michael R. Boh Center for Child Development

Dear Parent(s),

Welcome to the Developmental Assessment Clinic (DAC). We are sending you this intake form in order to learn more about your child's developmental history and the challenges your child is experiencing. The Intake Form must be completed and returned to our office to begin the evaluation process. Thus, please do not skip any sections. If any information is submitted incompletely, there will be delays with processing. Please submit your completed packet by email (CCDintake@ochsner.org) or by using the fax number or mailing address below.

Please use the checklist before returning the Intake Form to ensure we have all the necessary information to support your child and family.

Thank you!

_____ Complete all relevant questions on the Intake Form. Please pay special attention to pages that request information about other providers that have cared for or evaluated your child. Provide us as much of the information requested about these providers as possible so that, with your permission, we can contact them about your child.

_____ If you have copies of any recent evaluations psychological, developmental testing, speech/language, hearing, vision) please include them.

_____ If your child is between the ages of 3 and 21 years old and is receiving special services at school, please incluse any copies of their IEP or the results of any testing the school conducted.

If you need assistance in completing the Intake Form please call 504-493-2019, and we will assist you with your questions. We look forward ot working with you and your family.

Developmental Assessment Clinic Intake Form

Today's Date: _____

Parent/Caregiver: Please complete this form to the best of your knowledge. If questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

BASIC INFORMATION		
Child's Name:	Race/Ethnicity:	
Preferred Name:	Date of Birth:	
Person Completing Form:	Current Age:	Gender: M / F
Child's School:	Grade:	
FAMILY INFORMATION		
Primary Caregiver Name:	Legal Guardian? YES NO	
Relationship to Child:	*circle one:* Biological Step Adoptive	
DOB/ Age:	Phone #: Email:	
Occupation:	Place of Employment:	
Caregiver #2 Name: *(if applicable)*	Legal Guardian? YES NO	
Relationship to Child:	*circle one:* Biological Step Adoptive	
DOB/ Age:	Phone #: Email:	
Occupation:	Place of Employment:	
Caregiver #3 Name: *(if applicable)*	Legal Guardian? YES NO	
Relationship to Child:	*circle one:* Biological Step Adoptive	
DOB/ Age:	Phone #: Email:	
Occupation:	Place of Employment:	
Caregiver #4 Name: *(if applicable)*	Legal Guardian? YES NO	
Relationship to Child:	*circle one:* Biological Step Adoptive	
DOB/ Age:	Phone #: Email:	
Occupation:	Place of Employment:	

Marital Status of the Child's Biological or Adoptive Parents:	*If divorced, does the other parent have:*
□ Married, when _____ □ Divorced, when _____ □ Separated, when _____ □ Live with partner, when _____ □ Other – Please Describe: _____	□ Sole Custody □ Shared or Joint Custody □ Visitation □ Supervised Visitation □ No Visitation Rights □ Other – Please Describe: _____

*******IMPORTANT: A legal guardian must be present at initial appointment. If there is joint or shared custody, please bring copies of legal documentation of custody arrangement.********

Sibling Information (full, half, step, living, or deceased):

Name	Age	Sex	Grade	Relationship to child?	Living with child?

Others Living in the Home with the Child:

Name	Age	Sex	Relationship to child?

REASON FOR SEEKING SERVICES

Referral source: _____

***Considering the primary reason you contacted or were referred to the Michael R. Boh Center for Child Development, what concerns/questions do you have about your child development or behavior.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Has your child received a formal diagnosis of Autism Spectrum Disorder? YES NO
If yes, please submit a copy of your child's most recent evaluation.

If your child already has a diagnosis, are you coming for

- **On-going care**
- **Second opinion**

Have you, any family members, teachers or physicians been concerned about a medical, developmental, psychological, language, motor, or other diagnosis? If so, what was the diagnosis and who made the diagnosis?

- ☐ Autism/Autism Spectrum Disorder/Asperger's
- ☐ Attention and/or Hyperactivity (ADHD)
- ☐ Behavioral Problems
  - ☐ Anxiety
  - ☐ Tantrums
  - ☐ Aggressive
- ☐ Communication problems
- ☐ Coordination problems
- ☐ Developmental Delay
  - Speech or Language Delay
  - Fine motor problems
- ☐ Feeding/eating difficulties
- ☐ Genetic or chromosomal
- ☐ Intellectual disability
- ☐ Learning or academic problems

☐ Social skills difficulties

PREGNANCY & DELIVERY

During pregnancy, did child's mother experience any of the following? *(check all that apply)*

☐ Suffered from an illness (*specify*: _____)
☐ Had an accident (*specify*: _____)
☐ Had an accident (*specify*: _____)
☐ Had surgery (*specify*: _____)
☐ Used tobacco/smoked cigarettes
☐ Used alcohol
☐ Used illicit drugs (*specify*: _____)
☐ Took medication (*specify*: _____)
☐ Premature labor/threatened miscarriage
☐ Excessive vomiting
☐ Preeclampsia/toxemia
☐ Gestational diabetes
☐ Other: _____

Length of Pregnancy:	Birth Weight:
APGARS Score *(if known)*:	Was your child in the NICU? ☐ YES ☐ NO If YES, how long: _____

Type of Labor: ☐ Spontaneous ☐ Induced ☐ Scheduled

Type of Delivery: ☐ Normal (vaginal) ☐ Cesarean ☐ Breech
If cesarean, why?

During delivery, did any of the following occur? *(check any that apply)*

☐ Umbilical cord issue (e.g., cord wrapped around neck or limb)
☒ Fetal distress
☐ Other:
_____

Did any of the following complications occur with your child after birth? *(check all that apply)*

☐ Jaundice, if yes, did baby receive light therapy
☐ Breathing problems, if so did baby receive oxygen
☐ Seizures
☐ Intraventricular hemorrhage
☐ Other_____
☐ Needed respirator/resuscitation
☐ Turned blue
☐ Vomiting or diarrhea
☐ Meconium staining or aspiration

DEVELOPMENTAL MILESTONES

Milestone	Approximate Age Met	Age Unknown, but No Concern	Age Unknown, but Delayed
Language/Communication			
Made eye contact		☐	☐
Waved bye-bye		☐	☐
Gave high five		☐	☐
Babbled		☐	☐
Responded to name		☐	☐
Indicated that he/she wants something using gestures, such as pointing		☐	☐

Said mama or dada for that specific person		☐	☐
Spoke single words		☐	☐
Spoke 2 words together (“want milk”)		☐	☐
Spoke in sentences		☐	☐
Gross Motor Skills		☐	☐
Rolled over		☐	☐
Sat alone		☐	☐
Crawled		☐	☐
Walked alone		☐	☐
Walked up and down stairs holding rail		☐	☐
Jumped up		☐	☐
Pedaled a tricycle		☐	☐
Fine Motor Skills		☐	☐
Pincer grasp (picked up small food items using thumb and another finger)		☐	☐
Pushes button with single finger		☐	☐
Ate with utensils		☐	☐
Scribbled with crayon		☐	☐
Stacks blocks (how many)		☐	☐
Draws circle		☐	☐
Play Skills		☐	☐
Looks for object dropped out of sight		☐	☐
Dumps objects or takes objects out of a container		☐	☐
Pushes toy car or truck		☐	☐
Pretend play (drinks from empty cup; feeds doll or stuffed animal)		☐	☐
Puts shape in shape sorter		☐	☐
Completes large shape puzzles		☐	☐
Recites alphabet or simple songs		☐	☐
Identifies colors, shapes, letters or numbers		☐	☐

Names colors, shapes, letters or numbers		☐	☐
Adaptive Skills		☐	☐
Undressed		☐	☐
Dressed independently		☐	☐
Toilet trained		☐	☐

Has your child ever lost any skills or gone backwards in development? YES NO
If yes, please explain:
_____
_____

MEDICAL HISTORY	
Name of your child's pediatrician/primary care doctor:	
Pediatric Group Practice Name:	
Phone:	Fax:
Hearing Information	
Approximate date of most recent hearing test:	Results: ☐ Normal ☐ Abnormal
Does your child have hearing loss? ☐ YES ☐ NO	If yes, specify which ear _____
Do you currently have any concerns about your child's hearing? ☐ YES ☐ NO	
Vision Information	
Approximate date of most recent vision test:	Results: ☐ Normal ☐ Abnormal
Is child prescribed corrective lenses? ☐ YES ☐ NO	If yes, specify for what _____
Do you currently have any concerns about your child's vision? ☐ YES ☐ NO	

Please tell us whether your child has problems now or in the past with:

	Yes	NO	Don't know	If yes, please explain
Eyes/Vision	☐	☐	☐	
Ear, Nose, Throat	☐	☐	☐	
Hearing	☐	☐	☐	
Teeth	☐	☐	☐	
Stomach/Intestines/Bowels	☐	☐	☐	

Heart Problems	☐	☐	☐	
Heart Rhythm problems	☐	☐	☐	
Lung/Breathing Problems	☐	☐	☐	
Blood problems (anemia, leukemia, etc)	☐	☐	☐	
Brain/Neurologic problems/seizures	☐	☐	☐	
Muscle or movement problems	☐	☐	☐	
Skin problems	☐	☐	☐	
Thyroid problems	☐	☐	☐	
Diabetes	☐	☐	☐	
Other endocrine/hormone problems	☐	☐	☐	
Joint or bone problems	☐	☐	☐	
Kidney Problems	☐	☐	☐	
Genetic or hereditary problems	☐	☐	☐	
Accidents or Injuries	☐	☐	☐	

Current Medications

Medication	Dose/Frequency	When Started	Used to Treat	Prescribed By

Please list any vitamins, herbals, or supplements your child takes:

_____

_____

_____

Please list any allergies (environmental, food, medication, other) that your child has:

_____

_____

Does you child have any special diet? ☐ YES ☐ NO

If so, what kind?

Sleep Problems

Do you have concerns about your child's sleep? ☐ YES ☐ NO

If yes, what concerns you?

_____

Please indicate your child's typical sleep schedule below

	Time Child Lies Down	Time Child Falls Asleep	Time Child Wakes Up	Naps (Time & Duration)
School Days				
Non-School Days				

Eating Problems

Do you have any concerns about your child's appetite or eating behaviors? ☐ YES ☐ NO

If yes, what concerns you?

_____

_____

_____

Surgeries/Hospitalizations: List Surgeries or operations your child has had below.

Surgery Type	Which Hospital	Date of Surgery

Testing

Has your child ever had any of the following:

- ☐ MRI or CT scan of the brain
- ☐ Genetic Testing
- ☐ Hearing test by a hearing specialist after birth
- ☐ Vision exam by a specialist

☐ Other procedures or medical tests.
If yes, to any of the above, please explain:

MENTAL HEALTH HISTORY

Has your child ever been under the care of a mental health provider (psychiatrist, psychologist, or other therapist)? ☐ YES ☐ NO
If yes, name of provider: _____ Date of Service: _____

Has your child has a previous psychological evaluation? ☐ YES ☐ NO
If yes, who completed it? _____ Date of Eval: _____
Please bring copies or any previous evaluations to your appointment.

Has your child ever been hospitalized for a psychiatric/behavioral reason? ☐ YES ☐ NO
If yes, what facility? _____ Date of Admit: _____

Has your child ever had any thoughts of harming him/herself or others? ☐ YES ☐ NO
If yes, please explain:
_____
_____
_____

Has your child ever attempted to harm him/herself or others? ☐ YES ☐ NO
If yes, please explain:
_____
_____
_____

FAMILY HISTORY

Please check off any illnesses, conditions, or problems experienced by a blood relative or primary caregiver (even if not blood related) to the child, and specify the person's relationship to the child

	Condition	Relation to child, please indicate mother's or father's side of the family
☐	ADHD	
☐	Alcoholism	
☐	Anxiety	
☐	Autism Spectrum Disorder	
☐	Bipolar	
☐	Birth defect	
☐	Criminal Behavior	
☐	Depression	
☐	Developmental Delay	
☐	Drug addiction	

☐	Genetics/Hereditary	
☐	Heart disease	
☐	Intellectual Disability	
☐	Language or Speech problems	
☐	Learning Problems	
☐	Obsessive Compulsive Disorder	
☐	Pain Problems	
☐	Schizophrenia	
☐	Seizures	
☐	Suicide attempt	
☐	Suicide	
☐	Tics or other movement problem	

BEHAVIORAL HEALTH HISTORY

To help us understand your concerns, please check all that apply:

My child has unusual behaviors:

☐ Repeats the same behavior over and over
☐ Plays with toys in unusual ways (lines things up, counts them)
☐ Gets stuck on certain activities/topics
☐ Is especially sensitive to the sight, feel, sound, taste, or smell of things
☐ Flaps his/her hands
☐ Is interested in unusual things (paper clips, bottle caps, stop signs, string)
☐ Has trouble with change or transitions
☐ Repeats lines from movies, TV, etc.
☐ Uses your hand to show wants and needs
☐ Has odd movements or tics

My child has behavior problems:

☐ Is easily frustrated
☐ Acts impulsively
☐ Is overly active
☐ Is aggressive
☐ Runs away
☐ Does not obey
☐ Breaks rules
☐ Is in legal trouble
☐ Uses drugs or alcohol
☐ Is overly focused on weight loss
☐ Is destructive with toys or objects
☐ Tries to harm themselves
☐ Has temper tantrums

My child has trouble with attention:

☐ Has trouble concentrating
☐ Has a short attention span/is very distractible
☐ Makes careless mistakes
☐ Is often forgetful
☐ Is disorganized

I have concerns about my child's mood:

☐ Seems depressed or unhappy
☐ Seems too irritable
☐ Has sleep or appetite changes
☐ Is moody or has mood swings
☐ Has extreme happiness

My child seems anxious or nervous:

☐ Is too shy
☐ Is repeatedly bothered by upsetting thoughts (germs, illness, horrible events, "bad" thoughts, etc.)
☐ Feels driven to do things over and over

My child has social difficulties:

☐ Is teased or bullied
☐ Prefers to be alone
☐ Is not interested in having friends
☐ Is mean to other children
☐ Has poor eye contact

(wash, check, count, confess, arrange, even, collect, etc.) ☐ Is too anxious in social situations ☐ Has frequent nightmares ☐ Seems to worry too much ☐ Has trouble separating from parents/loved ones ☐ Has unusual fears or phobias	**I have concerns about my child's development:** ☐ Language delays or regression ☐ Motor delays or regression ☐ Toileting problems ☐ Problems with feeding ☐ Tries to eat non-food items or dangerous items
My child has problems thinking: ☐ Has unusual or false beliefs ☐ Hears or sees things ☐ Feels like others are out to get him	**My child has trouble learning/at school:** ☐ With letter identification or reading ☐ With spelling or writing ☐ With math ☐ With memory
Please describe any problem behaviors: _____ _____ _____ _____	
Please describe which discipline strategies are typically used with your child: _____ _____ _____	

FAMILY STRESSORS

Are there currently any major stressors affecting your family or your child (e.g., deaths, job change, school change, physical or sexual abuse, separation or divorce, use of drugs or alcohol in the family)?

_____

_____

_____

_____

STRENGTHS & ASSETS OF THE CHILD & FAMILY

What are your child's hobbies, interests, and favorite activities?

_____

_____

_____

Are they involved in any extracurricular activities or clubs? ☐ YES ☐ NO *(if yes, please describe)*

_____

_____

_____

What are your child's strengths and positive characteristics?

_____

_____

_____

_____

What are your family's strengths?

_____

_____

_____

_____

PARENT- AND TEACHER- REPORT MEASURES

Our clinic strives to obtain comprehensive data from all important individuals in your child's life to include as part of our evaluation process. As such, we will ask that each of your child's primary caregivers, teachers, and/or therapists fill out some additional standardized questionnaires. Please list the names and email addresses of those individuals below. Please list in order of priority (i.e., who knows your child the best should be listed first).

Primary Caregiver Name	Relationship	Email Address

Teacher or Therapist Name	Relationship	Email Address

Education/School/Therapy
School District where you live: Name of school and address: Current Grade: Grades repeated, if any: What kind of school: ☐ Religious ☐ Charter ☐ Public ☐ Other:
Has the school done any testing with your child? Please explain and attach a copy of the reports ☐ Yes ☐ No Does your child have an Individualized Education Program (IEP) or IFSP? Please explain and attach a copy of the reports ☐ Yes ☐ No Does your child have a 504 plan? Please explain and attach a copy of the reports ☐ Yes ☐ No Type(s) of classroom (check all that apply) ☐ Daycare ☐ Head Start

☐ Structured Preschool
☐ Regular Classroom
☐ Regular and special classes
☐ Home schooled
☐ Special classes, please describe:

Which special services does your child receive at school? (Check all that apply)

☐ Physical therapy
☐ Occupational therapy
☐ Speech/language therapy
☐ Vision impaired
☐ Hearing impaired
☐ Adaptive PE
☐ Bus/transportation services
☐ Resource room/special instruction
☐ Other:

Has your child ever been encouraged to leave, suspended, or expelled? ☐ YES ☐ NO
If yes, when and why:

_____

_____

_____

Describe any academic difficulties that your child is currently having in school:

_____

_____

_____

Describe any social difficulties your child has experienced:

_____

_____

_____

_____

Therapy Services
Age child started receiving special services: Has your child received Early Intervention (EI) services?

Please list any additional service(s) your child is currently receiving (outside the school setting)

Type Location How Long

_____
_____
_____
_____
_____

Previous Evaluations

Has your child been evaluated anywhere else for concerns about development, behavior, or school problems? Please explain including names/locations. If yes*, please attach a copy of the report(s) to this form.

_____
_____
_____
_____

What were the findings and diagnosis, if any?

_____
_____
_____
_____
_____

Consent for Assessment and Treatment
Michael R. Boh Center for Child Development

Client Name _____ Client Date of Birth _____

I voluntarily consent to the assessment and/or treatment offered by the Michael R Boh Center for Child Development at Ochsner I give my permission for the staff of Ochsner to perform assessment and/or treatment services.

This consent is for. ☐ Myself

☐ My child/family member (Your name. _____)

☐ Other (Explain _____)

CONFIDENTIALITY

I have been informed that I, my family member, or the interdict will receive testing and/or treatment from the Michael R Boh Center for Child Development at Ochsner These procedures may involve, but are not limited to: tests of cognitive, achievement, behavioral, perceptual, memory, and social/emotional functioning I understand that during the interview-intake process, I will be asked about the symptoms and history related to my, my family member's, the interdict's present problem. I have been informed about confidentiality and its limits.

Further,

- I understand that services will be provided by employees of Ochsner and its contractors and that, upon my signature, my, my family member's, the interdict's confidential information may be discussed among Ochsner employees in pursuit of the highest quality of assessment and/or treatment
- I understand that this consent may be rescinded or modified at any time with a written request to Ochsner
- I understand that these services may include direct, face-to-face contact, interviewing, records review, consultation with other professionals, and other related activities necessary to support these services
- I understand that there will be no exchange of printed or verbal information outside Ochsner without an appropriate release of information that I review and sign
- I understand and agree to, for professional training purposes, supervised students observing and/or participating in the rendering of my, my family member's, the interdict's services.
- If you chose to e-mail our staff, including a therapist or office assistant, your e-mail, as well as our response, may not be secure. As with any form of e-mail communication, confidentiality may be breached Please use e-mail with discretion. By signing this document, you acknowledge that e-mail is not a secure form of communication and the confidentiality of your child's information may be breached
- I understand all client information is strictly confidential The legal exceptions are
    - The client, parent/guardian or legal representative authorizes a release of information with a signature

- To comply with a court order
- There is suspicion of abuse or neglect involving a child, elder, or vulnerable person
- The client presents as a danger to self or others
- Record review as requested by insurance carrier provided authorization has been obtained

ATTENDANCE POLICY

Because progress is dependent on consistent attendance, each child must attend on a regular basis In fairness to both the children enrolled and those children on our waiting list, any child meeting one or more of the following criteria may be removed from your therapist's caseload

- 3 or more no shows (i.e , absences without cancelling)
- 3 or more last minute or same day cancellations
- Variable/reduced attendance rates
- Persistent tardiness

If you are late for an appointment, your session will still end at its scheduled time. However, your therapist reserves the right to reschedule the appointment if there is not enough time to complete the goals for that session (e g., testing appointments). If you are unable to keep a scheduled appointment, please call us at 504-842-3900 to cancel as soon as possible

I give my permission and consent for assessment and/or treatment, and I agree to the attendance policy.

_____ _____

Signature of Individual or Personal Representative by Law Date

_____

Personal Representative's Relationship/Authority

_____ _____

Signature of Ochsner Representative Date

NOTE: If the individual is a competent major, he or she is to sign, or make his or her mark on the first line If the individual is a minor, incompetent major, or unable to sign, the parent, guardian, or correspondent is to sign on the first line and fill in the second line

Policy and Procedure for No Shows and Late Cancellations

No-shows and late cancellations are very disruptive to the clinic schedule. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient and increases waiting list times. No-shows and late cancellations delay the delivery of services to other patients, some of who are in great need. Below are the policies and procedures that we have implemented regarding these situations.

A "no-show" is missing a scheduled appointment without any notification prior to the start of the appointment time. A "late cancellation" is cancelling an appointment without calling us to cancel 24 hours in advance of an intake and feedback or 48 hours in advance of a testing appointment.

INTAKE APPOINTMENTS

New clients who no-show for their first appointment will NOT be automatically rescheduled. Less than 24 hours advance notice for intake appointments will be considered a no-show. Monday appointments must be cancelled by the Friday before the appointment. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. *(No-show fees may apply.)* If the new client initiates a phone call requesting to be rescheduled after their first no show, they may first be returned to the waiting list. If the new client no-shows for an intake a second time, they will not be rescheduled and will have to seek services elsewhere.

TESTING APPOINTMENTS

Less than 48 hours advance notice of cancellation for testing will be considered a no-show. Monday appointments must be cancelled by the Friday before. If there is no-show for testing, the client may NOT be rescheduled. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. No-show fees *may* apply.

FEEDBACK APPOINTMENTS

Less than 24 hours advance notice for feedback appointments will be considered a no-show. Monday appointments must be cancelled by the Friday before the appointment. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis.

If a client no-shows for a feedback appointment, they will not be rescheduled and the final report will be mailed to the caregiver.

No-show / late cancellation fees are the FULL responsibility of the client – insurance companies do not pay for missed appointments.

By signing below, you are agreeing to the terms of this policy and you understand your responsibility in making scheduled appointments.

_____ _____

Signature Date

_____

Printed Name & Relationship to Child