All great minds *do not* think alike.

Hello,

Thank you for recently contacting the Center for Developing Minds (CDM). The evaluations at our clinic are designed to describe the range of your child's abilities. Our unique individualized approach may include a thorough medical examination, behavioral observation, psychological testing and/or neurodevelopmental testing to best determine how your child's strengths and weaknesses impact their behavior and the learning process.

How to begin:

If you would like to schedule your child's initial appointment at the CDM, please complete the new patient questionnaire and other forms that are included with this note. The forms are also available on our website. http://www.devminds.com/appointments.htm

When the completed intake documents are received in our office, we will promptly contact you to schedule your visit. You may submit these forms via email (info@devminds.com), fax (408.358.1802), mail (15951 Los Gatos Blvd., Suite 6, Los Gatos, CA 95032), or you may drop them off in person. We will not be able to schedule an appointment without these forms on hand.

Learn more about the clinic:

We invite you to attend an upcoming CDM Orientation Session, which are held on the second Thursday of each month, from 9:00-9:30am. This is a no-cost opportunity to visit the facility and meet with one of our behavioral and developmental pediatricians to learn more about the testing, therapeutic, and evaluation services we offer.

Throughout the year, the clinicians at the Center for Developing Minds also host interactive Child Development Chats -- where topics in child behavior, developmental concerns, and parenting questions can be discussed free-of-charge. Please use this link for details about upcoming presentations: http://www.devminds.com/seminars2.htm

Please do not hesitate to contact us at 408-358-1853 if you have any questions about completing the new patient paperwork or need further assistance. We look forward to meeting you and your child.

Sincerely,

Center for Developing Minds Administrative Staff

Note: Full payment for services is due at the time of appointment. To research whether your insurance policy will reimburse you for a new patient appointment at the CDM, please contact our office staff to attain relevant CPT service codes. Members of Santa Clara Valley Health Plan require pre-authorization to initiate services.

Center for Developing Minds
New Patient Intake Questionnaire

PLEASE MAIL, FAX, OR EMAIL COMPLETED FORMS TO (408) 358-1802 OR INFO@DEVMINDS.COM
QUESTIONS? PLEASE CALL (408) 358-1802

I. GENERAL INFORMATION

DATE COMPLETED:	/ /	NAME OF PERSON COMPLETING FORM		

PATIENT					
NAME:	LAST	FIRST		MIDDLE	
DOB:	/ /	AGE		MALE ☐	FEMALE ☐
PARENT 1 ◯ Mom ◯ Dad ◯ Guardian	LAST	FIRST	MI	PHONE # ◯ Primary?	
PARENT 2 ◯ Mom ◯ Dad ◯ Guardian	LAST	FIRST	MI	PHONE # ◯ Primary?	
ADDRESS ◯ Mom ◯ Dad ◯ Same Household	STREET	CITY		STATE	ZIP
EMAIL ADDRESS 1				◯ Mom ◯ Dad ◯ Guardian	
EMAIL ADDRESS 2				◯ Mom ◯ Dad ◯ Guardian	

REFERRAL				
REFERRED BY:	○ Pediatrician ○ Friend ○ Teacher ○ Specialist	○ Therapist ○ Advertisement ○ Website ○ Other	NAME/SPECIFIC INFORMATION:	
REFERRAL CONCERNS:	○ Attention (AD/HD) ○ Anxiety ○ Autism ○ Behavioral ○ Bipolar	○ Depression ○ Developmental ○ Dyslexia ○ Dysgrafia ○ Learning concerns	○ School problems ○ Social skills ○ Speech/Language ○ Tics ○ Other	
Please describe the concerns you have about your child:				
What do you hope to gain from visiting our center?				
Why do you think your child has these issues?				

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II. MEDICAL HISTORY

NAME OF PATIENT (CHILD'S) PRIMARY PEDIATRICIAN:				
ADDRESS	STREET	CITY	STATE	ZIP
OFFICE PHONE:		OFFICE FAX #:		
OTHER PHYSICIANS/CLINICIANS (leave blank if does not apply)				
○ NEUROLOGIST		PHONE #:		
○ PSYCHIATRIST		PHONE #:		
○ OTHER:		PHONE #:		
○ OTHER:		PHONE #:		

Is your child adopted? ☐ Yes ☐ No

		YES	NO	IF YES, PLEASE EXPLAIN.
PREGNANCY/BIRTH HISTORY	Bleeding during the pregnancy	○	○	
	Gained less than 20 lbs.	○	○	
	Gained more than 35 lbs.	○	○	
	Too high blood pressure	○	○	
	Too high blood sugar/diabetes	○	○	
	Physical trauma	○	○	
	Maternal infections	○	○	
	Maternal alcohol use	○	○	
	Maternal tobacco use	○	○	
	Exposure to other toxins (e.g. cocaine, marijuana)	○	○	
	Previous miscarriages	○	○	
	Previous premature births	○	○	
	Cesarean section	○	○	
	Forceps assisted delivery	○	○	
	Length of pregnancy______ weeks Birth weight _______ lbs. ______ oz			Twins? Yes No Apgar Scores _____ 1 min _____ 5 min

		YES	NO	IF YES, PLEASE EXPLAIN.
PATIENT NEWBORN HISTORY	Newborn jaundice	○	○	
	Stayed in the newborn intensive **care unit**	○	○	
	Transfusion	○	○	
	Required oxygen	○	○	
	Intubation	○	○	
	Was infant discharged with mother?	○	○	

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		YES	NO	IF YES, PLEASE EXPLAIN.
PATIENT HEALTH HISTORY	General symptoms (fever, weakness, tiredness, etc.)	○	○	
	Trouble with weight (too little, too much, or major weight changes)	○	○	
	Trouble with eyes (poor vision, tendency to cross, etc.)	○	○	
	Trouble with ears or hearing (any specific hearing tests?)	○	○	
	Ear infections	○	○	
	Trouble with nose, mouth, or throat (stuffy nose, difficulty swallowing, etc.)	○	○	
	Heart problems (heart murmurs, ECG or heart tests, etc.)	○	○	
	Lung problems (asthma or wheezing, tuberculosis, etc.)	○	○	
	Genital or urinary problems (frequent urination, abnormal genitals, etc.)	○	○	
	Kidney problems	○	○	
	Stomach or abdominal problems (vomiting, stomach ache, constipation, etc.)	○	○	
	Trouble with bones or muscles (weakness, deformities, etc.)	○	○	
	Skin problems (birthmarks or other skin marks, lumps or bumps, etc.)	○	○	
	Tics, twitches or makes odd noises	○	○	
	Headaches	○	○	
	Loss of consciousness/head injury	○	○	
	Seizures/Convulsions	○	○	
	Meningitis/infection of the brain	○	○	
	Body stiffness	○	○	
	Body looseness or floppiness	○	○	
	Wets underwear during day	○	○	
	Wets bed at night	○	○	
	Soils underwear/bowel accidents	○	○	
	Serious illness (in bed and unresponsive for several days)	○	○	
	Lead poisoning	○	○	
	Allergies	○	○	
	Hospitalizations	○	○	(If yes, please list dates and purpose)
	Surgeries	○	○	(If yes, please list dates and purpose)

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MEDICATION HI STORY

PAST MEDICATION(S) Name of medications used for a long time in the past:	Dosage(s)	Dates

CURRENT MEDICATION(S) Name of medications currently on:	Dosage(s)	Dates

SLEEP HISTORY

	YES	NO
Does your child have trouble falling asleep at night?		
Does your child have problems staying asleep?		
Does your child snore or have noisy breathing during sleep?		
Does your child have very heavy sleep?		
Does your child take frequent naps during day?		
Is your child frequently tired during the day?		
How long does it take your child to fall asleep?	______	**min**
How much sleep does child get each night?	______	**hrs**

DEVELOPPMENTAL HISTORY

(PLEASE CHECK APPROPRIATE BOX FOR EACH ROW)

Developmental Milestone	Cannot Recall	0-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	4-5 years	5-6 years
Rolled over									
Sat up without support									
Crawled									
Spoke first words (Mama, Dada, etc.)									
Walked alone (10 steps)									
Walked up stairs									
Put words together (Daddy bye-bye, Mama home, etc.)									
Spoke 2-3 word sentences									
Fully bladder trained									
Fully bowel trained									
Caught a big ball									
Spoke clearly so strangers understood									
Able to dress self									
Able to tie shoelaces									

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SPEECH & LANGUAGE HISTORY		YES	NO
	LISTENING		
	Does your child have difficulty with listening?		
	Does your child misunderstand spoken directions?		
	Does your child confuse speech sounds?		
	Does your child misunderstand figures of speech or sarcasm?		
	SPEAKING		
	Does your child have difficulty with speaking?		
	Does your child have slow or labored speech?		
	Does your child use grammar incorrectly?		
	Does your child jumble up sounds in words?		
	Does your child have difficulty telling a story from beginning to end?		
	Which languages are spoken at home?	Which is your child's primary language?	

BEHAVIOR HISTORY		YES	NO
	EMOTIONAL RESPONSE		
	Does your child bang his/her head?		
	Does your child have temper tantrums?		
	Does your child hold his/her breathe when upset?		
	Does your child cry easily?		
	Is your child physically aggressive towards others?		
	Is your child verbally aggressive towards others?		
	MOOD		
	Does your child appear sad, empty or irritable much of the time?		
	Is your child uninterested in participating in many activities?		
	Does your child make negative comments about him/herself?		
	Is your child overly withdrawn?		
	Has your child talked of harming him/herself?		
	ANXIETY		
	Does your child excessively worry?		
	Does your child experience frequent unfounded illness or pain?		
	Does your child avoid going to school?		
	Does your child have more fears than other children do?		
	OBSESSIONS, COMPULSIONS OR PERSEVERATIONS		
	Does your child insist upon doing things his/her way?		
	Does your child have difficulty making transitions?		
	Does your child perform repetitive movements such as rocking or flapping?		
	Does your child insist on having things done in a certain way all of the time?		
	Does your child line up his/her toys?		
	SOCIAL SKILLS		
	Does your child have difficulty in conversing with others?		
	Does your child have difficulty understanding the body language of others?		
	Does your child have problems "acting cool"?		
	Does your child have problems taking other people's perspective?		
	Does your child have difficulty making friends and acquaintances?		
	SENSORY PROCESSING		
	Does your child frequently bump into objects, trip or fall?		
	Is your child a picky eater?		
	Is your child overly sensitive to certain sounds?		
	Does your child show an aversion to textures of clothing?		

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ATTENTION HISTORY		Yes	No
	MENTAL ENERGY		
	Is your child frequently tired during the day?		
	Does your child have highly inconsistent patterns of attention?		
	Does your child have difficulty initiating and or completing work?		
	Does your child have inconsistent school performance?		
	Does your child tend to work on things that only interest him?		
	PROCESSING CONTROLS		
	Do background noises and extraneous activities easily distract your child?		
	Does your child tend to focus on irrelevant information?		
	Do you frequently have to repeat instructions for your child?		
	Does your child have difficulty remembering recently learned information?		
	Does your child frequently daydream and “space out”?		
	Does your child have difficulty concentrating?		
	Does your child miss parts of explanations and information?		
	Does your child have difficulty delaying gratification?		
	PRODUCTION CONTROLS		
	Is your child impulsive?		
	Does your child say and do things in an inappropriate manner?		
	Does your child have difficulty staying on task?		
	Does your child have difficulty recognizing his/her errors?		
	Does your child have difficulty learning from his/her mistakes?		
	Does your child show indifference to punishment and or rewards?		
	Does your child overreact to minor situations?		
	PLANNING AND ORGANIZATION CONTROLS		
	Does your child lose things of value?		
	Is your child’s room frequently messy?		
	Is your child frequently bored?		
	Does your child have difficulty planning?		
	Does your child have difficulty establishing priorities?		
	Does your child procrastinate and dawdle?		

III. FAMILY INFORMATION

FAMILY INFORMATION	FAMILY HISTORY OF:	MOTHER	FATHER	BROTHER(S)	SISTER(S)	OTHER RELATIVES
	Learning difficulties					
	Trouble paying attention					
	Hyperactivity					
	Autism Spectrum Disorders					
	Mental Retardation					
	Drug or alcohol abuse					
	Speech problems					
	Depression					
	Anxiety/Compulsions					
	Manic Depression					
	Other					

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FAMILY INFORMATION, CONTD.

PLEASE LIST FAMILY MEMBER WHO LIVE AT HOME:

NAME	RELATIONSHIP	AGE	OCCUPATION

FAMILY SUPPORTS	YES	NO
Does your child have siblings that are not living at home?		
Is your child adopted?		
Is your child in foster care?		
Are the parents separated?		
Are the parents divorced?		
Who has legal custody of your child?		

IV. EDUCATION INFORMATION

EDUCATION HISTORY

CURRENT SCHOOL AND DISTRICT:		GRADE:	
SCHOOL CONTACT AND PHONE #:			
SCHOOL ADDRESS:	STREET	CITY	STATE	ZIP

SPECIAL EDUCATION SERVICES			
PLEASE MARK & DESCRIBE ANY SPECIAL EDUCATION SERVICES THAT YOUR CHILD HAS RECEIVED:			YEAR(S) RECEIVED:
O	SPEECH THERAPY		
O	PHYSICAL THERAPY		
O	OCCUPATIONAL THERAPY		
O	SPECIAL EDUCATION TEACHER		
O	SMALL CLASSROOM		
O	ABA		
O	COUNSELING		
O	OTHER		

WHY DOES YOUR CHILD RECEIVE SPECIAL EDUCATION SERVICES?

	YES	NO
Does your child have a 504 plan?		
Does your child have an individualized education plan (IEP)?		
Has your child's school performed a psychoeducational evaluation?		
Is your child receiving educational support outside of school?		
HAS YOUR CHILD HAD DIFFICULTY LEARNING ANY OF THE FOLLOWING:		
Writing the alphabet		
Telling time		
Sounding out words		
Spelling accurately		

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	Understanding what he/she reads		
	Reading fast enough		
	Writing neatly		
	Drawing pictures		
	Performing math calculations		
	Understanding math word problems		
	Writing reports		
	Remembering instructions for an assignment		
	Knowing how to study for a test		
	Managing his/her homework		

V. ADDITIONAL INFORMATION

INTERESTS & STRENGTHS	
	DESCRIBE YOUR CHILD'S PARTICULAR INTERESTS.
	WHAT ARE YOUR CHILD'S STRENGTHS AND TALENTS?
	PLEASE INCLUDE ANY OTHER INFORMATION YOU THINK MIGHT BE VALUABLE.

CONSENT FOR REPORT RELEASE		
	AFTER SEEING A CLINICIAN AT THE CENTER FOR DEVELOPING MINDS, A REPORT IS TYPICALLY DRAFTED. UPON CONSENT LISTED BELOW, PLEASE INDICATE WHETHER YOU WOULD LIKE THE FOLLOWING REPORTS COMPLETED BY THE LISTED PROVIDER SENT TO YOUR CHILD'S PRIMARY PEDIATRICIAN:	
	INITIAL EVALUATION REPORT BY DEVELOPMENTAL/BEHAVIORAL PEDIATRICIAN	**PARENTS INITIALS:**
	PSYCHOEDUCATIONAL EVALUATION OVERVIEW BY EDUCATIONAL PSYCHOLOGIST	**PARENTS INITIALS:**
	SPEECH AND LANGUAGE REPORT BY SPEECH AND LANGUAGE PATHOLOGIST	**PARENTS INITIALS:**
	OCCUPATIONAL THERAPY REPORT BY OCCUPATIONAL THERAPIST	**PARENTS INITIALS:**

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