CHILD INFORMATION

Today's Date:	Child's Name:	Gender:

Age:	Birthdate:	Height:	Weight:	Diagnosing Physician:
Referred By: Specialty:		Primary Care Physician: Phone/Fax:		Phone/Fax: Diagnosis Given: Date of Diagnosis:

CHILD'S CURRENT LIVING SITUATION

Tell us about all of the caregivers that your child currently lives with *(e.g., biological mother, adoptive father, grandmother).*
Describe:

Please provide information on who your child **currently** lives with below:

Parent/Caregiver 1		Parent/Caregiver 2	
Name:	Age:	Name:	Age:
Occupation:		Occupation:	
Ethnic/Cultural Background:		Ethnic/Cultural Background:	
Cell Phone:	Work Phone:	Cell Phone:	Work Phone:
Email:		Email:	
Highest Level of Education:		Highest Level of Education:	

If your child **does not live with both biological parents**, who has legal custody of the child?
(Please provide copies of the custody agreement).

Name:	Relationship to Child:

Tell us about your child's **siblings:** *(Please list all siblings, whether or not they live with your child)*

Name:	Age:	Gender:	Full/Step/Half?	Lives w/ Child?
Name:	Age:	Gender:	Full/Step/Half?	Lives w/ Child?
Name:	Age:	Gender:	Full/Step/Half?	Lives w/ Child?
Name:	Age:	Gender:	Full/Step/Half?	Lives w/ Child?

Lives w/ Child? O yes O no

Tell us about the **languages** used in home.

What languages does the child use (List PRIMARY language first):	What other languages is your child exposed to?
1. 2.	1. 2.

PRENATAL/PREGNANCY/BIRTH

Tell us about the **birth/biological mother**.	
Age at conception:	Assisted reproduction? O yes O no Describe:

Did the **birth/biological mother** have any of the following medical problems before/during/after pregnancy?	
Maternity difficulties (pre, peri, and/or post). O yes O no Describe:	
Maternal hospitalization (pre, peri, and/or post). O yes O no Reason:	
Maternal emotional and/or physical complications (pre, peri, and/or post). O yes O no Describe:	
Exposure to illicit drugs during pregnancy (including marijuana). O yes O no 1. 2. 3.	Maternal medications/supplements during pregnancy. O yes O no 1. 2. 3.
Exposure to alcohol: O yes O no	

Tell us about the **delivery.**			
Was your child born full-term? O yes O no	Birth Weight:	If premature, how early?	If overdue, how late?

Check all that applied to the **delivery.**			
O Spontaneous O Forceps O Multiple births O Other:	O Breach O Head first O Cord around neck	O Induced. Reason: O Cesarean. Reason:	

Which of the following applied to the **infant**? Check all that applied.		
O Breathing problems	O Sleeping problems	O Jaundice; Bilirubin lights used?
O Feeding problems	O Excessive crying	O Unusual appearance? Describe:
O Rash	O Seizure/convulsions	O Other:

DEVELOPMENTAL HISTORY

During your child's **first three years**, tell us if you observed any of the following.		
O irritability	O breathing problems	O colic
O difficulty sleeping	O eating problems	O temper tantrums
O failure to thrive	O excessive crying	O withdrawn behavior
O poor eye contact	O early learning problems	O destructive behavior
O convulsions/seizures	O twitching	O unable to separate from parent
O other:		

Has your child ever lost skills? *(e.g., words, eye contact).* O yes O no Describe: *(what skills, what age)*

Answer the following about your child's **language development.** At what age did your child begin to:		
Skill	**Currently Needs Assistance**	**Age Mastered *(e.g., 18 months)***
Babble	O	
Use single words	O	
Use phrases (2 words)	O	
Use short sentences (3-4 words)	O	
Use longer sentences (5+ words)	O	
Answer the following about your child's **motor development.**		
Roll Over	O	
Sit unaided	O	
Crawl	O	
Stand up	O	
Walk unaided	O	
Answer the following about your child's **self-help skills.**		
Toileting for urination *(day)*	O	
Toileting for urination *(day and night)*	O	
Toileting for bowel movements *(day)*	O	
Toileting for bowel movements *(day and night)*	O	
Washes hands	O	
Brushes teeth	O	
Sits for meals	O	
Feed self	O	
Uses eating utensils *(e.g., fork, spoon)*	O	
Drinks from open cup	O	
Uses a straw to drink	O	

MEDICAL HISTORY

Tell us if your child has experienced any of the following.		
Type	**Age**	**Describe**
Head injury		
Loss of consciousness		*(include duration)*
Hospitalization		*(include reason)*
Surgery		
Infections (e.g., ear)		
Other:		
Other:		
Other:		
Other:		

Tell us about your child's **allergies.** *(You may also attach a document if easier.)*		
Food Allergies *(not sensitivities):* O yes O no List:	Medication Allergies: O yes O no List:	Environmental Allergies: O yes O no List:

Tell us about your child's **immunizations.** *(Immunization records should be submitted before admission.)*
Is your child up to date on immunizations? O yes O no If no, why not?

Please tell us about the **physicians** your child has seen.				
Type	Name	Email and Phone	Diagnosis/Results	Last Visit Date
Pediatrician/ Behavioral Pediatrician				
Psychiatrist				
Psychologist				
Geneticist				
Neurologist				
Other:				
Other:				

Please tell us about your child's history of **medical testing.**		
Type	**Date of Test**	**Results**
EEG		
MRI		
CT Scan		
Hearing		
Ophthalmology		

Genetic O Buccal swab O Whole exome O Other:		
Other:		
Other:		
Other:		
Other:		
Other:		

Please tell us about your child's **medication history.** Begin with **current** medications. *(You may also attach a document if easier.)*

Name of Medication	Prescribing Physician	Dose Range and Frequency	Date Started and Ended	Reason for Ending	Current or Past
					O Current O Past
					O Current O Past
					O Current O Past
					O Current O Past
					O Current O Past
					O Current O Past

Please tell us about your child's **supplement/vitamin history.** Begin with **current** supplements.
(You may also attach a document if easier.)

Name of Supplement	Prescribing Physician	Dose Range and Frequency	Date Started and Ended	Reason for Ending	Current or Past
					O Current O Past
					O Current O Past
					O Current O Past
					O Current O Past
					O Current O Past
					O Current O Past

CURRENT CONCERNS ABOUT YOUR CHILD

Tell us about your **current concerns** about your child.

Related to behaviors:
- O does not follow directions/ noncompliance
- O difficult transitions
- O sometimes seems "spacey"
- O poor sustained attention
- O fearful or anxious
- O temper tantrums
- O self-injury
- O aggression
- O self-stimulatory behaviors
- O rigidities/ritualistic behaviors
- O preoccupations
- O unsafe behavior
- O impulsive behavior
- O hyperactive behavior

Related to social skills:
- O plays alone
- O peer relationships
- O adult relationships
- O toy play
- O recreational play

Related to self help skills:
- O urine/bm training
- O toileting
- O washing hands
- O food selectivity
- O meal related skills
- O sleep problems
- O dressing skills

Related to speech and language skills:
- O speech/articulation
- O AAC devices
- O spontaneous initiations
- O prompted language
- O reciprocal conversations

Other Skills:
- O cognitive skills
- O academic skills
- O fine motor skills
- O gross motor skills

Related to services:
- O school
- O regional center
- O IHSS
- O respite
- O medical
- O resources

Related to medical:
- O diagnostic clarification
- O hearing
- O medication
- O referrals to medical specialists (neuro, geneticist)

Please answer the following questions about your child.

Can your child be described as clumsy/uncoordinated? O yes O no
Does your child have a fine motor delay? O yes O no
Does your child have a gross motor delay? O yes O no
Does your child have a dominant hand? O yes O no If so, which hand: O Left O Right

What is your child's current eating behavior?
O normal O overeats
O picky O over stuff
O weight loss/gain

Do you have any oral motor concerns?
O none O difficulty swallowing
O drooling O gagging

Is your child on a special diet? O yes O no
Describe:

Do you have concerns about your child's food repertoire?
O yes O no
Describe:

Tell us of any recent **major stressors** on the family or your child, experienced within the last year.

- O marital discord/fighting
- O birth/adoption of another child
- O custody disagreement
- O parent deployment
- O abandonment by a parent
- O child neglect
- O parental disagreement about child rearing
- O separation
- O divorce
- O sibling conflict
- O single parent family
- O parent's mental health concerns
- O parent's substance abuse
- O financial problems
- O physical abuse
- O parent-child conflict
- O death in the family
- O involvement in juvenile court
- O involvement with social services/child protective services
- O sexual abuse
- O other:

Tell us about your **family supports.**

O belong to parent support group
O belong to sibling support group
O have a religious/cultural affiliation
List:

REGIONAL CENTER FUNDED SERVICES

Answer the following questions about your **Regional Center.**		
Is your child currently a client of a Regional Center? O yes O no		Name of Regional Center:
O Early intervention unit (up to age 3 years) O School age unit (3 years and above)		Name of Service Coordinator: Phone & Email:
Age when child was accepted as client:	Date when RC services began:	Age when Regional Center services began:

Please tell us about your **current** Regional Center Services					
Type	**Individual hours/wk**	**Group hours/wk**	**Provider name**	**Email & Phone**	**Start date**
Infant Stimulation/ Early Intervention					
Speech Therapy					
Occupational Therapy					
Physical Therapy					
Social Skills/Group					
Recreation Therapy					
Behavioral Therapy O home based O center based					
Other (list):					
Other (list):					

SCHOOL BASED SERVICES

Please **list all schools/programs** your child has attended, beginning with the **current** school:

Month and Year Started	Age Started	School Name (Current school first)	Type of Class (e.g., general education, autism-specific SDC, preschool mixed)	Days, hours per week	# Children in class	# Adults in class *(including teacher)*

Answer the following questions about your **Specialized Services.**

Date of first IEP:	School district:	Special education categorization *(e.g., ASD, Speech or Language Impairment, Other Health Impairment)*
Date of most recent IEP:	District contact person:	District contact email & phone:

Please tell us about your child's **current** school based services

Type	Individual hours/wk	Group hours/wk	Provider name	Email & Phone	Start date
Speech Therapy					
Occupational Therapy					
Adaptive Phys. Education					
Physical Therapy					
BII/BID Services *(i.e., behavioral aide, in school consultation)*					
Resource					

Other (list):					
Other (list):					

PRIVATE/INSURANCE FUNDED SERVICES

Please tell us about your child's **current** private/insurance funded services and activities

Type	Individual hours/wk	Group hours/wk	Provider name	Email & Phone	Start date
Behavioral Therapy O home based O center based					
Speech Therapy					
Occupational Therapy					
Physical Therapy					
Other Activities (list):					
Other Activities (list):					
Other Activities (list):					
Other Activities (list):					
Other Activities (list):					

Please MAIL or EMAIL copies of your child's most recent reports and documents, including:

- Copy of your insurance card, front and back
- Regional Center assessments and IFSP – Individual Family Service Plan or IPP – Individual Program Plan
- School district assessments and IEP – Individual Educational Plan
- Any other relevant reports/evaluations, such as most recent psychological testing, speech and language, OT, neurological, developmental pediatrician, child psychiatrist, etc.

Along with our registration sheet and this questionnaire to:

Annette Lovato
KidsConnect
Resnick Neuropsychiatric Hospital at UCLA
760 Westwood Plaza, room 78-215
Los Angeles, CA 90024
alovato@mednet.ucla.edu

Your child will be added to our waitlist when we receive the above information.

Registration packets will be processed in the order received.

We will call you to confirm the receipt of your registration packet and that your child has been added to our waitlist.

Wishing you and your family well. Thank you!