Baker Victory Healthcare Center
Evaluation and Treatment Center
790 RIDGE RD
LACKAWANNA, NY 14218
Phone: 716-828-7586
Fax:716-828-7589

PARENT INTAKE FORM

The Evaluation and Treatment Center 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 https://www.olvhs.org/evaluation-and-treatment-center.

Intake process

Please note, our team of clinicians carefully reviews the intake packet and additional information you provide to ensure we are able to answer your questions and are the right fit for your child.
- It is possible we will request standardized testing through the school district (if not recently done).
-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 parent intake form
- ☐ Copies of previously completed evaluations, standardized testing, and school plans (as indicated throughout the intake forms)

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

Once we have received your completed intake form, we will contact you within **5 business days** to schedule your visit or discuss placement on a potential waitlist. If you have not heard from us by that time, please contact us at 716-828-7586.

OLV EVALUATION AND TREATMENT CENTER 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 LAST NAME												Relationship to child:					
													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 LAST NAME												Relationship to child:					
													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
Were you referred to a specific provider in our practice? (indicate below)	☐ Yes	☐ No

Developmental Pediatrician		Psychologists			
☐	Ted J. Andrews, MD, PhD	☐	Alissa Schiske, PsyD	☐	PhD

Concerns and Strengths

What are your top 3 concerns regarding your child?

1.	
2.	
3.	

When were the concerns about your child first noted?

What are your child's strengths?

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
Are you seeking a second opinion? *If yes, we will need a copy of the initial assessment	☐ Yes*	☐ No

Is there anything outside of the above that you are hoping to get from your visits with our clinic?

Child's Name: DOB:

FAMILY COMPOSITION

Please check all who live with the child and write in their names:

☐	Biologic mother	☐	Biologic father
☐	Adoptive mother	☐	Adoptive father
☐	Step-mother	☐	Step-father
☐	Grandmother	☐	Grandfather
☐	Guardian(s)	☐	Other adult(s) (explain):

If shared custody arrangement, please explain:

Siblings

Name (First & Last)	Full, half, adoptive, or step. If half, maternal or paternal.	Age	Date of Birth	Medical or Behavioral Issues	Lives in the home?
			M M / D D / Y Y Y Y		☐
			M M / D D / Y Y Y Y		☐
			M M / D D / Y Y Y Y		☐
			M M / D D / Y Y Y Y		☐
			M M / D D / Y Y Y Y		☐

FAMILY COMPOSITION (continued)

Parents

Parent name	Age	DOB: M M / D D / Y Y Y Y	School level completed:	
Present occupation				
General health				
Parent name	Age	DOB: M M / D D / Y Y Y Y	School level completed:	
Present occupation				
General health				

If child is adopted or in foster care, has this been discussed with the child? ☐ Yes ☐ No

Does your child attend any of the following?

☐	Daycare (list days/times child attends)	
☐	Before or After-school program	
☐	Extracurricular activities (list)	

Are there any notable stressful events that the child or family is currently experiencing or have experienced? ☐ Yes ☐ No

If yes, please explain:

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:

Child's Name: DOB:

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 Asperger's)	☐	☐	☐		
Bipolar Disorder	☐	☐	☐		
Depression	☐	☐	☐		
Developmental Delay	☐	☐	☐		
Intellectual Disability (previously Mental Retardation)	☐	☐	☐		
Language Disorder	☐	☐	☐		
Learning Disability	☐	☐	☐		
Mood Disorder	☐	☐	☐		
Obsessive-Compulsive Disorder	☐	☐	☐		
Oppositional Defiant Disorder	☐	☐	☐		
Other (specify):	☐	☐	☐		

Medication History				
Does your child **currently take** medication 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**	**Dates 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**	**Dates taken**
Please list **ANY OTHER MEDICATIONS** your child **currently takes** for issues **other than** inattention, anxiety, behavior, mood, or sleep.				☐ Check if none

Child's Name: DOB:

Name of Medication	Reason for taking	Dosage	Frequency	Dates Taken

Please list **ANY VITAMINS or SUPPLEMENTS** your child **currently takes**: ☐ Check if none

Name of Medication	Reason for taking	Dosage	Frequency	Dates 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 CDC vaccination schedule?	☐ 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		
Has your child received counseling services outside of school?	☐ Yes*	☐ No
*If yes, indicate name of therapist & dates seen:		

Any Hospitalizations or Surgeries?	☐ Yes	☐ No

Date	Reason	Location

Child's Name: _____DOB: _____

Pregnancy, Labor, & Delivery History			
Age of mother when child was born: _____ years			
	Yes	No	Comments
Any history of pregnancy loss/miscarriage in mother?	☐	☐	
Was the child a product of a multiple birth pregnancy?	☐	☐	
Any problems during pregnancy? If yes, describe:	☐	☐	
Any medications taken? If yes, name & reason taken:	☐	☐	
Cigarette/tobacco/eCigarette use during pregnancy?	☐	☐	
Alcohol use during pregnancy?	☐	☐	
Drug use during pregnancy (eg, marijuana, cocaine, etc.)	☐	☐	
Was the child born via cesarean section (c-section)?	☐	☐	
Any problems with labor &/or delivery? If yes, describe:	☐	☐	

Newborn History			
Gestational age of baby: _____weeks		Birth Weight: _____pounds _____ounces	
Birth place (hospital, city/state):			
	Yes	**No**	**Comments**
Any problems at birth or as a newborn?	☐	☐	
Any birth defects or injuries?	☐	☐	
Special Care or Intensive Care stay? _____ days	☐	☐	
Any jaundice that received treatment?	☐	☐	
Had colic or cried excessively as infant?	☐	☐	
Breast fed? How long? _____	☐	☐	

Medical Tests: including, but not limited to, EEG, MRI, CT scan, EKG, genetic or metabolic testing, etc.?			☐ Yes ☐ No
Year	**Type of Testing**	**Where Done?**	**Results**

Lead testing

Any history of elevated lead level? ☐ Yes ☐ No If yes, peak level _____; date_____

Hearing testing

Has child passed hearing screens through doctor or school? ☐ Yes ☐ No

Has formal hearing testing ever been done at speech/hearing center or ENT? ☐ Yes ☐ No

If yes, date done: _____; results: _____

ALLERGIES				☐ Yes ☐ No
Check all that apply:				
☐ Medication	☐ Food	☐ Latex	☐ Environmental	☐ Other
Please describe the allergy and the child's reaction:				

Child's Name: _____DOB: _____

Current or Past Medical Symptoms			
	Yes	**No**	**Comments**
Serious/chronic medical problems? If yes, describe.	☐	☐	
Serious illnesses or infections?	☐	☐	
Serious injury, burns, or broken bones?	☐	☐	
Known genetic problems?	☐	☐	
Has growth been normal?	☐	☐	
Small for age or underweight?	☐	☐	
Large for age or overweight?	☐	☐	
Head injury, loss of consciousness, concussion?	☐	☐	
Staring spells?	☐	☐	
Seizures or convulsions?	☐	☐	
Frequent headaches or migraines?	☐	☐	
Problems with eyes or vision?	☐	☐	
Problems with hearing?	☐	☐	
Motor tics (blinking, head tilts, facial or arm movements, etc.)?	☐	☐	
Vocal tics (sniffing, grunting, throat clearing, etc.)?	☐	☐	
Tooth issues or cavities?	☐	☐	
Brushes teeth at least twice daily?	☐	☐	
Regularly sees dentist for routine care?	☐	☐	
Frequent ear infections with chronic antibiotics and/or tubes?	☐	☐	
Respiratory or lung problems (asthma, pneumonia, etc.)?	☐	☐	
Heart problems or arrhythmias?	☐	☐	
Dizziness or fainting spells?	☐	☐	
Gastroesophageal reflux?	☐	☐	
Unexplained or recurrent episodes of vomiting?	☐	☐	
Constipation?	☐	☐	
Diarrhea or other bowel problems?	☐	☐	
Soils pants or has bowel accidents?	☐	☐	
Daytime urinary incontinence ('wets' pants)?	☐	☐	
Wets at night?	☐	☐	
Thyroid or hormone problems?	☐	☐	
Very flexible body?	☐	☐	
Parts of body or muscles seem stiff?	☐	☐	
Birth marks?	☐	☐	
Skin problems?	☐	☐	
Current or past use of: ☐tobacco ☐alcohol ☐drugs	☐	☐	☐N/A

SLEEP HISTORY			
	Yes	**No**	**Comments**
Does your child have trouble falling asleep?	☐	☐	
Does your child have trouble staying asleep/night awakenings?	☐	☐	
Does your child have early morning awakenings?	☐	☐	
Does your child snore?	☐	☐	
Does your child have difficulty waking in the morning?	☐	☐	
Does your child have daytime fatigue?	☐	☐	

Child's Name: DOB:

SLEEP HISTORY (continued)			
	Yes	No	Comments
Does your child have frequent nightmares?	☐	☐	
Does your child have any night terrors or sleep walking?	☐	☐	
Does your child take any supplements or medications to help with sleep (eg, melatonin, clonidine, guanfacine)? If yes, specify:	☐	☐	
Is anyone present when child falls asleep?	☐	☐	
Describe where child sleeps:			

NUTRITION/DIET			
	Yes	No	Comments
Any history of or current feeding/eating difficulties?	☐	☐	
Is child a picky eater?	☐	☐	
Does child eat from all the food groups (meat/protein, dairy, complex carbohydrates, fruits, vegetables)?	☐	☐	
Any special dietary modifications? If yes, specify.	☐	☐	
Takes any vitamins or supplements? If yes, specify.	☐	☐	
Below please list some of the foods from each food group that the child regularly eats:			
Meats/proteins:			
Dairy or dairy alternative:			
Complex carbohydrates:			
Fruits:			
Vegetables:			
What is child's main source of iron? (common sources include red meats, leafy green vegetables, beans/legumes, nuts, vitamins with iron)			
What is child's main source of calcium/vitamin D? (common sources include dairy products or dairy alternatives, supplements/vitamins)			
How many cups are consumed daily of the following:	# cups/day	Comments	
Milk			
Water			
Juice			
Soda/sugar-sweetened drinks			

DEVELOPMENTAL HISTORY		
	Approximate Age Accomplished	Too Young
Sat without support	months	☐
Walked	months	☐
Spoke first words	months	☐
Spoke in two-three word sentences	months	☐
Speech could be understood by strangers	months	☐
Toilet trained during the day	months	☐
Dry at night	months	☐
Rode a tricycle	years	☐

Child's Name: DOB:

DEVELOPMENTAL HISTORY (continued)		
	Approximate Age Accomplished	**Too Young**
Able to dress self	years	☐
Able to tie shoes	years	☐
Read simple words	years	☐

Has the child ever had a regression in skills (loss of previously acquired skills) outside of those that occur during breaks from school? ☐ Yes ☐ No

If yes, please explain: _____

CURRENT DEVELOPMENTAL SKILLS				
	Above Average	**Average**	**Below Average**	**Doesn't Apply**
Ability to understand spoken words (receptive language)	☐	☐	☐	☐
Ability to speak clearly (expressive language)	☐	☐	☐	☐
Conversation skills (turn taking, use of polite language)	☐	☐	☐	☐
Ability to use fingers to write legibly or draw (fine motor)	☐	☐	☐	☐
Ability to use large muscles to run or play (gross motor)	☐	☐	☐	☐
Ability to make friends/play with other children (social skills)	☐	☐	☐	☐
Ability to dress, feed, and/or clean self (adaptive skills)	☐	☐	☐	☐

LEARNING AND BEHAVIORAL SYMPTOMS					
*N/A = Not Applicable as too young	**Yes**	**Some**	**No**	**N/A***	**Comments**
Difficulty learning colors or shapes	☐	☐	☐		
Difficulty learning numbers or counting	☐	☐	☐		
Difficulty learning the alphabet/letters	☐	☐	☐		
Difficulty learning sight words	☐	☐	☐	☐	
Difficulty sounding out or reading words	☐	☐	☐	☐	
Difficulty with reading comprehension	☐	☐	☐	☐	
Difficulty writing sentences or spelling	☐	☐	☐	☐	
Handwriting difficult to read					
Difficulty with math calculations	☐	☐	☐	☐	
Difficulty with math word problems	☐	☐	☐	☐	
Difficulty completing work independently	☐	☐	☐	☐	
Takes extended amount of time to do school work	☐	☐	☐	☐	
Does not seem to retain learned information	☐	☐	☐		
Difficulty with multi-step problem solving	☐	☐	☐		
Difficulty following directions	☐	☐	☐		
Believes he/she not as 'smart' as other peers	☐	☐	☐	☐	
Clumsy/not coordinated	☐	☐	☐		
Poor hygiene	☐	☐	☐		
Often complains of not feeling well before school	☐	☐	☐	☐	
Often objects or refuses to go to school	☐	☐	☐	☐	
Frequent school absences	☐	☐	☐	☐	

Child's Name: DOB:

LEARNING AND BEHAVIORAL SYMPTOMS (continued)				
	Yes	Some	No	Comments
Repetitive checking, counting, touching things, etc	☐	☐	☐	
Particular about keeping hands clean	☐	☐	☐	
Doing things over & over before they seem 'right'	☐	☐	☐	
Difficulty finishing work as has to do it over & over	☐	☐	☐	
Perfectionist	☐	☐	☐	
Picking habits- skin, scabs, fingernails, etc.	☐	☐	☐	
Frequently collects or hoards items	☐	☐	☐	
Unable to throw out items, even if not of value	☐	☐	☐	
Unusual habits (please explain)	☐	☐	☐	
Uses a pacifier	☐	☐	☐	
Sucks thumb/fingers	☐	☐	☐	
Body rocks	☐	☐	☐	
Fearful of gaining weight	☐	☐	☐	
Overeats or binges on food	☐	☐	☐	
Intentionally vomits food after eating	☐	☐	☐	
Hoards and/or hides food	☐	☐	☐	
Worries often or seems anxious	☐	☐	☐	
Frequent headaches, bellyaches, or body aches	☐	☐	☐	
Has many fears (if yes, explain)	☐	☐	☐	
Panics easily	☐	☐	☐	
Self-conscious in public or during performances	☐	☐	☐	
Has difficulty separating from caretakers	☐	☐	☐	
Has low self-esteem or self-confidence	☐	☐	☐	
Moody/mood swings or rapid mood changes	☐	☐	☐	
Irritable	☐	☐	☐	
Feels sad, appears tearful, or cries often/easily	☐	☐	☐	
Has lost interest in things he/she once enjoyed	☐	☐	☐	
Recent changes in eating or sleeping patterns	☐	☐	☐	
Makes negative comments about self	☐	☐	☐	
Has talked about or attempted to hurt or kill self	☐	☐	☐	
Difficulty being consoled or self-soothing	☐	☐	☐	
Head banging	☐	☐	☐	
Severe temper tantrums/outbursts	☐	☐	☐	
Aggressive behavior towards others	☐	☐	☐	
Difficulty making friends	☐	☐	☐	
Difficulty picking up on social cues	☐	☐	☐	
Difficulty understanding someone else's point of view or emotions	☐	☐	☐	
Difficulty using/understanding eye contact/gestures				
Difficulty initiating or maintaining conversations	☐	☐	☐	
Difficulty understanding tone of voice, jokes, sarcasm	☐	☐	☐	

Child's Name: DOB:

LEARNING AND BEHAVIORAL SYMPTOMS (continued)				
	Yes	Some	No	Comments
Literal or concrete in thought	☐	☐	☐	
Play is repetitive (does same thing over & over)	☐	☐	☐	
Difficulties with pretend/imaginative play	☐	☐	☐	
Strong interest in specific toys/topics	☐	☐	☐	
Unusual interests (please explain)	☐	☐	☐	
Repetitive motor behaviors (eg, hand flapping, toe walking, etc)	☐	☐	☐	
Sensitive to sights, smells, noises, tastes, or touch	☐	☐	☐	
Strong-willed personality	☐	☐	☐	
Impatient	☐	☐	☐	
Overly sensitive	☐	☐	☐	
Shuts down when upset	☐	☐	☐	
Rigid or inflexible in thinking	☐	☐	☐	
Shy or slower-to-warm-up around new people	☐	☐	☐	
Routine oriented or does not like change	☐	☐	☐	
Difficulties with transitions				
Tends to be more emotionally reactive or intense	☐	☐	☐	
Tends to be more negative in thought	☐	☐	☐	

TANTRUMS			
	Yes	No	Comments
Does child have frequent tantrums? (ie, emotional outbursts that range from yelling to aggression)	☐	☐	
How often? _____ per day/week (circle one)			
How long do tantrums last: on average? _____ minutes at their worst? _____ minutes			
Triggers?			
What helps child to calm?			

SCREEN TIME			
	Yes	No	Comments
Does child use electronic devices with screens (e.g., TV, video games, tablets, smartphones, computers, etc.)?	☐ *	☐	*Hours of use per day? _____
Are there TV/devices w/ screens in child's bedroom?	☐	☐	
Does child use TV/screens within 2 hrs. of bedtime?	☐	☐	

BEHAVIOR MANAGEMENT IN THE HOME (Please check all that apply)				
	Yes	No	Effective?	Comments
Time-out	☐	☐		
Ignoring	☐	☐		
Earning or taking away privileges	☐	☐		
Yelling	☐	☐		
Spanking	☐	☐		
Other punishment	☐	☐		
Other (describe)	☐	☐		

Child's Name: DOB:

SAFETY			
	Yes	**No**	Please Explain:
Does child place non-food items in mouth?	☐	☐	
Does child wander/elope?	☐	☐	
Is the home child-proofed?	☐	☐	☐ N/A
Does anyone smoke or vape/eCig use in home (including basement) or car?	☐	☐	
Are there any guns in the home?	☐	☐	If yes:
	☐	☐	Are the guns themselves locked?
	☐	☐	Are guns stored in a locked place?
	☐	☐	Are bullets stored separately from guns?
Is the child exposed to yelling or physical disputes in the home?	☐	☐	
Has child ever experienced abuse (emotional, physical, and/or sexual)?	☐	☐	

BIOLOGIC FAMILY MEDICAL AND PSYCHIATRIC HISTORY							
Indicate whether someone in the child's biological family has the following:	**Yes**	**No**	**Not sure**	**Affected Relative**			
				Mother	**Father**	**Sibling**	**Other (explain)**
ADHD/ADD or Attentional issues	☐	☐	☐	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Arrhythmia or Heart problems before age 50. If yes, describe:	☐	☐	☐	☐	☐	☐	☐
Autism spectrum disorders	☐	☐	☐	☐	☐	☐	☐
Behavior problems or trouble with the law	☐	☐	☐	☐	☐	☐	☐
Bipolar disorder	☐	☐	☐	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental delays (late to walk or talk)	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Drug abuse	☐	☐	☐	☐	☐	☐	☐
Genetic diagnosis	☐	☐	☐	☐	☐	☐	☐
History of abuse (emotional, physical, or sexual)	☐	☐	☐	☐	☐	☐	☐
Intellectual disability (aka, mental retardation)	☐	☐	☐	☐	☐	☐	☐
Learning difficulties or disabilities (reading, writing, math, etc)	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Obsessive-Compulsive Disorder (OCD)	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐	☐
Speech disorder	☐	☐	☐	☐	☐	☐	☐
Sudden death before age 50	☐	☐	☐	☐	☐	☐	☐
Suicide attempts	☐	☐	☐	☐	☐	☐	☐
Tics/Tourette's syndrome	☐	☐	☐	☐	☐	☐	☐
Other conditions/diagnoses - specify:	☐	☐	☐	☐	☐	☐	☐
Is there anything else you would like us to know about your child or family at this time?							

Child's Name: DOB:

School (or Preschool) Information:				
Does your child currently attend school (or preschool)? ***If yes**, complete below.			☐ Yes*	☐ No
Current School/Preschool:				
School District:				
Grade Level:				
Repeated any grades?	☐ Yes*	☐ No	If yes, which grade(s)?:	
Ever suspended/expelled?	☐ Yes*	☐ No	If yes, explain:	
Classroom Setting:	☐ Regular	☐ Co-taught	☐ Blended/integrated	
	☐ 15:1:1	☐ 12:1:1	☐ 8:1:1	☐ 6:1:1
COVID 19 IMPACT Please describe your child's educational experience during the academic year 2020-2021	☐ Hybrid	☐ In person	☐ Fully remote	
	☐ Homeschooled	(Registered homeschooled with the State Dept. of Education)		

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? ***If yes**, please check all the services that your child receives (denote if received privately):			☐ Yes*	☐ No
☐	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 or ENL/ESL	☐	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**	

Child's Name: _____ DOB: _____

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

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.

_____ _____

Parent/Guardian Signature Date

Please mail completed form to:

OLV EVALUATION AND TREATMENT CENTER
790 Ridge Rd.
Lackawanna, NY 14218

or

Please e-mail completed form to:

ETCintake@olvhs.org