
# Intake Request

Child's Name: _____

Date of Birth: _____

Gender:

☐ Male
☐ Female

Parent's Name: _____
Home #: _____
Cell #: _____
Work #: _____
Email: _____

Parent's Name: _____
Home #: _____
Cell #: _____
Work #: _____
Email: _____

Other Caregivers Name: _____
Home #: _____
Cell #: _____
Work #: _____
Email: _____

Siblings:

1. Name
   Age
   Gender
   ☐ Male
   ☐ Female
   Any special needs
   ☐ Yes
   - If yes please list diagnosis _____
   ☐ No

2. Name
   Age
   Gender
   ☐ Male
   ☐ Female
   Any special needs
   ☐ Yes
   - If yes please list diagnosis _____
   ☐ No

3. Name
   Age
   Gender
   ☐ Male
   ☐ Female
   Any special needs
   ☐ Yes
   - If yes please list diagnosis _____
   ☐ No

Child's Home Address: _____

Who resides in the home
with the child?

Initial parent concerns:

How old was your child when you **FIRST** had concerns about development?

Age: _____

Describe your child's strengths:

**CURRENT** parent concerns (Check all that apply):

- ☐ Late Development
  - Please specify _____
- ☐ Regression / Loss of Skills
  - Please specify _____
- ☐ Challenging behavior (Check all that apply)
  - ☐ Tantrums
  - ☐ Aggression
  - ☐ Self-injurious behavior
  - ☐ Property destruction
  - ☐ Other: Please specify _____
- ☐ Language / Communication
  - Please specify _____
- ☐ Following Directions
- ☐ Social interactions (Check all that apply)
  - ☐ Peer interactions
  - ☐ Sibling interactions
  - ☐ Interactions with other Adults / Teachers
  - ☐ Other: Please specify _____
- ☐ Daily Living Skills (Check all that apply)
  - ☐ Toileting
  - ☐ Handwashing
  - ☐ Dressing
  - ☐ Showering
  - ☐ Eating
  - ☐ Other: Please specify _____
- ☐ Community Inclusion (Check all that apply)
  - ☐ Participation in group activities such as sports or birthday parties
  - ☐ Family outings (e.g., eating at a restaurant, visiting a playground, visiting a store)
  - ☐ Tolerating a doctor / dentist visit
  - ☐ Tolerating a hair cut
  - ☐ Other: Please specify _____
- ☐ Additional concerns: Please specify_____

Child's school/daycare: _____
Phone #: _____
Address: _____
Case Manager/Director: _____
Teacher/Classroom: _____

School History

Has your child's teacher / school informed you they have concerns about any of the below?

- ☐ Yes (Check all that apply)
  - ☐ Challenging behavior
  - ☐ Language / Communication
  - ☐ Following Directions
  - ☐ Social interactions (Check all that apply)
    - ☐ Peer interactions
    - ☐ Interactions with other Adults / Teachers
  - ☐ Hyperactivity
  - ☐ Distractibility
  - ☐ Difficulty completing homework
  - ☐ Additional comments: _____
- ☐ No

Pediatrician: _____ Phone: _____

Has your child received a diagnosis? Yes ☐ / No ☐

If yes:

Diagnosis: _____
Date received: _____
Who made the diagnosis? _____
Family history of this diagnosis (or related)? _____

Does your child have any medical conditions? Yes ☐ / No ☐

If yes, please describe: _____

Does your child have any allergies? Yes ☐ / No ☐

If yes, please describe: _____

If yes, does your child require an EpiPen? Yes ☐ / No ☐

Please list ALL current medications and supplements with dosage information:

Name of medication: _____
Dosage: _____

Name of medication: _____
Dosage: _____

Name of medication: _____
Dosage: _____

Please list ALL treatment / services your child **currently** receives:

| SERVICE | PROVIDER | FREQUENCY |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Prior treatment / service history

Please list all services that your child received in the past.

| SERVICE | PROVIDER | Approximate start and end dates of service |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Gold Coast Children's Center requires each family to participate in parent / caregiver training. Please describe some areas you feel would be helpful to address through parent training.

Gold Coast Children's Center, LLC is not in-network with any insurance companies and is therefore considered an "out-of-network" provider. With your permission we will inquire about your current benefits and out of network reimbursement. A quote of benefits and/or authorization does not guarantee payment. We are happy to provide you with the information to assist you in seeking reimbursement from your insurance company; but please be reminded that every family is solely responsible for timely payment for services rendered, and this is not contingent or conditioned upon getting reimbursed by your insurance company.

Insurance Company: _____
Phone #: (_____)_____
Name of Policyholder: _____
DOB: _____
Employer: _____
Relation to child: _____
Policy #: _____
Group #: _____

Please list your child's favorites:

Food:

Toys:

Drinks:

Activities:

Characters:

Shows:

Other preferred items/activities:

How did you hear about Gold Coast Children's Center? (Check all that apply)

- ☐ Friend / Family Member
  - Name: _____
- ☐ Doctor / Professional serving my child
  - Name: _____
- ☐ Publication
  - Name: _____
- ☐ Social Media (e.g., Facebook group)
  - Name: _____
- ☐ Google Search
- ☐ Other: _____

Intake request completed by:

Name: _____ Date: _____

Thank you for your application someone will contact you within 48 business hours.

Click here to submit. By submitting this form you acknowledge all information is correct to the best of your knowledge.

IEP FORM

DIAGNOSTIC REPORT

FRONT OF INSURANCE CARD

BACK OF INSURANCE CARD