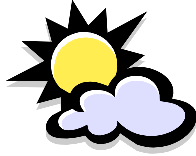
Date of intake:____________________ **Start Date:______________**



Center for New Beginnings

Sarah Ashe, Director
(706 437-0505

P.O. Box 1066
Waynesboro, Ga. 30830

INTAKE INFORMATION:

(The parent or guardian should complete this form)

I. General Information

Name: _________________________________ Date of Birth: _________ Age:______
Gender of child:________ County child lives in:_______________ Race:__________
Parent/Guardian: ____
Address:______________________________City/Zip:_________________________
Phone: Home: _________________________Work:_________________________
Cell: __________________________Email: _________________________
Emergency Contact:____________________ Phone:___________________________
School/Daycare: ____Grade:______
Teacher's Name: ____

Who referred the child to this center: _______________________________________

Child Lives with: ☐ **Mother** ☐ **Father** ☐ **Both Parents**
☐ **Other_______________________________________**

List those currently living in the home:

Name:	Age:	Relation to Child:	Level of Education:	Occupation:

Check from the list of Services that you are interested in:

□ **Occupational Therapy** □ **Speech Therapy** □ **Physical Therapy**
□ **Special Needs Play Group** □ **Shadowing** □ **Parent Support Group**
□ **After-school Tutoring** □ **Family Counseling** □ **Social Group**
□ **Individual Counseling** □ **Intensive Autism Training**

II. Medical History

Who is the child's Primary Care Physician? ___________________________________
(Also list any specialists the child sees and their phone number)
____
____

List Current Therapies

Current medical issues or diagnosis: ____
____
____
____

Please list all hospitalizations and surgeries: ___________________________________
____
____
____

List of Medications	Dosage	Taken for

Type of Insurance:____

Allergies: ____-
____

III. Developmental History

Please check all concerns that apply and when you first noticed them

- ☐ **Frequent Illnesses_________**
- ☐ **Vision__________________**
- ☐ **Emotional_______________**
- ☐ **Hyperactivity____________**
- ☐ **Frequent Headaches_______**
- ☐ **Hearing_________________**
- ☐ **Behavior_________________**
- ☐ **Speech__________________**
- ☐ **Seizures_______________**
- ☐ **Ear infections__________**
- ☐ **Motor_________________**
- ☐ **Sensory_______________**
- ☐ **Sleeping______________**
- ☐ **Eating ________________**
- ☐ **Learning ____________**
- ☐ **Developmental delay_______**

What was the child's weight at birth?

____

Were there any complications during the pregnancy or birth?

____
____
____

What types of activities does he/she enjoy? ___________________________________
____

What types of activities does he/she dislike? __________________________________
____

Please give any other information that you think may help with the meeting of your child and family's needs:

____
____

IV. This Section of information is optional. It will not affect any services received from the Center. These are statistics used when we apply for grants. All information is confidential and will not be used without your consent

Marital Status of parents: __single __separated __married__ divorced __widowed

Please check yearly income:

__ 9,000-10,500
__10,501-12,200
__12,201-13,800
__13,801-15,800
__15,801-20,700
__20,701-25,000
__25,001-29,000
__29,001-34,000
__34,001-37,000
__37,001-45,000
__over 45,000