THE UNIVERSITY OF
ALABAMA AT BIRMINGHAM

Civitan-Sparks Clinics
Touching Lives, Changing Futures

Dear Parent/Guardian:

We are sending you an Intake Form to complete based on a request by you or one of your child's health care or educational providers to conduct a comprehensive evaluation of your child. The Intake Form must be completed and returned to our office to begin the evaluation process and schedule the appointments. Appointments cannot be made before this information is received. Please use the checklist below before returning the Intake Form to ensure we have all the information we need to schedule the appropriate appointments for your child.

_____ ***Complete all relevant questions on the Intake Form.*** Please ***pay special attention to pages 6 and 7*** that request information about other providers that have cared for or evaluated your child. Provide us as much of the information requested about these providers as possible so that, with your permission, we can contact them about your child.

_____ Be sure to complete and sign the ***Insurance information/authorization on pages 8 and 9*** of the Intake Questionnaire.

_____ If you have ***copies of any recent evaluations*** (psychological, development testing, speech/language, hearing, vision) please include them when you mail us your Intake Form.

_____ If your child is between the ages of 3 and 21 years old and is receiving special services at school, please include any copies of their ***IEP or the results of any testing the school*** conducted if you have that information available to you.

_____ If you are the ***child's guardian and not the birth or adoptive parent*** please include copies of the ***Guardianship papers*** (court order or Power of Attorney) with your Intake Form.

If you need assistance in completing the Intake Form, please call 205-934-5471 or toll free 800-822-2472, and we will assist you with your questions.

We look forward to working with you and your family. Upon receipt of the above information, you can expect to hear from our office within a few weeks. If you do not hear from us, please call to make sure we have received this information.

Community Health Services Bldg 20
930 20th Street South, Suite 101
205.934.5471
Fax 205.975.2380
www.uab.edu/civitansparks

The University of
Alabama at Birmingham
Mailing Address:
CH19 307
1720 2nd AVE S
BIRMINGHAM AL 35294-2041

Mailing Address
UAB CIVITAN-SPARKS CLINICS
1720 2nd Avenue South
CH19 307
Birmingham, AL 35294-2041

Chart #_____
(for office use only)

I. IDENTIFYING INFORMATION OF INDIVIDUAL REFERRED TO CLINIC:

Child's Name: _____
Last First Middle Nickname

Birth date: _____ Age_____ Sex: __ Male __ Female

Name of person completing form: _____

Relationship to child: _____ Date Completed: _____

Address: _____ Home Phone: _____

_____ Second Phone: _____
City State Zip County

_____ _____ _____ _____
Relative or friend for emergency contact Relationship Home phone Additional phone

_____
Current physician Address Phone

Referred to this clinic by: _____

_____ _____
Address City State Phone

If school or other agency has tested your child, please explain here or attach records from that evaluation. Name of school, evaluator, and date of test: _____

_____

_____

II. FAMILY INFORMATION:

Mother's Name: _____ Age: _____ Education (highest grade):____
Place of Employment: _____ Telephone: _____
Father's Name: _____ Age: _____ Education (highest grade): ____
Place of Employment: _____ Telephone: _____

Child's Legal Guardian:
__ Both Birth Parents
__ Birth Mother
__ Birth Father
__ Adoptive Parents
__ Department of Human Resources
__ Other (please explain)

Marital Status of Birth Parents:
__ Not Married
__ Married
__ Separated
__ Divorced
__ Father remarried
__ Mother remarried

If your child does not live with her/his legal guardian, please indicate with whom child lives.

_____

Brothers and Sisters: (Please include and indicate half-brothers/sisters).

Name	Age	Learning & Medical Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IIIA. Reason(s) for requesting evaluation (developmental or behavioral concerns/academic progress-What behaviors are you most concerned about)? _____

_____

_____

_____

IIIB. Has your child ever been given a medical, developmental, psychological, language, motor, or other diagnosis? If so, what was the diagnosis and who made the diagnosis?

_____

_____

IIIC. Have you, any family members, teachers or physicians ever questioned whether your child has:

_____ Language Delay
_____Hyperactivity/ADD/ADHD
_____Hearing Problems
_____Vision Problems
_____Autism Spectrum Disorders/Autism/Pervasive Developmental Delay/Asperger
_____Physical Disability/Cerebral Palsy
_____Mental Retardation
_____Developmental Delays
_____Learning Disability

IIID. How would you describe your child? How does he/she get along with other children and adults?

_____

_____

_____

IIIE. Has your child ever had a cognitive, developmental, or IQ test? _____Yes _____No
If yes please attach of copy of the report to this form.

IVA. **MOTHER'S PREGNANCY HISTORY:**
Number of pregnancies:_____ Number of miscarriages:_____
Were there any problems experienced during pregnancy with this child? Yes____ No_____
If Yes, please explain:_____

_____

_____

Were any substances used during pregnancy? (e.g., alcohol, tobacco, drugs). Yes ____ No_____
If so, please specify._____

Labor and Delivery above pregnancy:		Yes	No	Remarks
Labor:	Normal	____	____	_____
Delivery:	Normal	____	____	_____
	Forceps	____	____	_____
	C-section	____	____	_____
	Other	____	____	_____

IVB. **BIRTH HISTORY**:

Hospital child was born in: _____

Birth weight: Pounds ____ Ounces_____ Length: _____

If your child experienced difficulties during labor or delivery, please describe:_____

_____

Type of Nursery (answer all that apply): Yes No

Well-baby ____ ____

Intensive Care ____ ____

If intensive care nursery, please explain:_____

_____

Length of stay in nursery:_____days (routine? extra days?)

V. **FAMILY HISTORY**

Is there a history on either side of the child's family of any of the following conditions?

Condition	Father's Side Yes	Father's Side No	Mother's Side Yes	Mother's Side No	Relationship to child (Parent, sibling grandparent, aunt, uncle, cousin)
Hyperactivity					
Learning Problems					
Mental Retardation					
Speech or language problems(s)					
Severe emotional problem (s) (e.g., depression, schizophrenia, bipolar disorder, etc)					
Epilepsy (seizures)					
Birth defect(s)					
Stillbirths					
Alcohol/drug problems(s)					
Tics or other movements					
Diabetes					
Thyroid problem(s)					
Hearing loss/problem(s)					
Other, specify					

VI. **PAST MEDICAL HISTORY**:

Childhood Illnesses Other Than Colds: Yes_____No ____

Type **How often** **Approximate Date**

_____

_____

_____

_____

Surgeries: Yes_____ No ____

Date Type Hospital name and location Reason

_____

_____

_____

_____

Other hospitalizations: Yes_____ No _____

Date Hospital name and location Reason

_____ _____ _____

_____ _____ _____

_____ _____ _____

Accidents Or Injuries: Yes____ No _____

Date	Type	
_____	_____	_____
_____	_____	_____
_____	_____	_____

If child is currently taking medications, please list below:

Type of medication	Dose	Reason

Does your child have allergies? Yes___No____If yes, explain_____

_____

Please answer the following about your child:

Immunizations Up-to-date: Yes_____ No _____ If no, explain_____

Seizures	Yes_____	No _____	If Yes, explain_____
Seizures with fever	Yes_____	No _____	If Yes, explain_____
Growth problems	Yes_____	No _____	If Yes, explain_____
Sleep problems	Yes_____	No _____	If Yes, explain_____
Dental problems	Yes_____	No _____	If Yes, explain_____
Vision problems	Yes_____	No _____	If Yes, explain_____
Hearing problems	Yes_____	No _____	If Yes, explain_____
Feeding problems	Yes_____	No _____	If Yes, explain_____

Current weight_____

Current feeding method (check all that apply): Bottle fed Breast fed_____Baby food_____
Table food_____Special diet_____

Do you have any concerns about what or how your child eats?	_____Yes	_____No
Is your child overly selective about what they will eat?	_____Yes	_____No
Do you have concerns about your child's weight?	_____Yes	_____No

DEVELOPMENTAL HISTORY (age at which your child could do the following or can use "early" and "late" and "on time" to describe if age is unknown):

Smile	_____	Short sentences	_____	Walk alone	_____
Coo/babble	_____	Phrases	_____	Feeds self	_____
Roll over	_____	Crawl	_____	Dresses self	_____
Sit alone	_____	Stand alone	_____	Toilet trained:	Bowel _____
Single words	_____				Bladder_____

Your child communicates by which of the following (check all that apply)

_____ Crying	_____ Sentences
_____ Playful sounds	_____ Sign language
_____ Pointing with index finger	_____ Picture Communication Boards/Schedules
_____ Words	_____ Eye pointing
_____ Phrases	_____ Electronic talking devices

How much of your child's speech is understandable to you? ____ Some ____ Most ___ All

How much of your child's speech is understandable to others? ____ Some ____ Most ___ All

Please give an example of words/phrases/sentences your child typically uses to communicate:

_____

_____

Hand preference: Right_____Left____Both_____Not sure_____
If your child has difficulty with coloring, fastening or handwriting please explain_____

Does your child have any problems:

Understanding what someone says	**Yes**____	**No** ____
Talking	**Yes**____	**No**_____
Reading	**Yes**____	**No**_____
Math	**Yes**____	**No**_____

Does your child prefer to play (mark any that apply):

Alone _____
With other children _____ (specify)
With all ages _____
With same age children _____
With younger children _____
With older children _____

Do you have any concerns about your child's social skills or play skills? Yes ___ No___
If Yes, please explain:_____
_____

What does child enjoy doing in his/her spare time? _____
_____

IX. **EDUCATION/THERAPY** (Please answer regardless of child's age or current school)
School district where you live: _____
Name of school and address: _____
_____ City ____ County _____ Private _____ Other (explain other)_____
Current grade _____ Teacher's name_____
Grades repeated, if any: _____
Type of classroom: Preschool _____ Regular classroom _____
Head Start _____ Regular and special classes _____
Home Schooled _____
Special classes _____ (Describe)_____
Does your child receive the following special services (check all that apply)?

Physical therapy	_____	Vision impaired	_____
Occupational therapy	_____	Adaptive P.E.	_____
Speech/language therapy	_____	Bus/transportation services	_____
Hearing impaired	_____	Resource room/special instruction	_____

Other, specify _____

Age child started receiving special services _____

If your child is <u>not</u> in school, please list any service(s) he/she is receiving

Type	Address	How long

Has the School or Early Intervention done any testing with your child? _____Yes _____No
If yes please attach a copy of the report to this form if you have one available.

Please complete any of the following pertaining to your child. It is very important that you furnish the complete address of each Agency/Provider you list.

Birth, Treatment, and School History Services Form

Name_____ **If your child's records are not under his/her current name, what name should we request records under?**_____

Type of Service Provider	Agency/Provider Name	Agency/Provider Address	Date(s) Seen
Place of Birth:			
Hospitalizations:			
Hospitalizations:			
Pediatrician:			
Neurologist			
Orthopedist			
Geneticist			
Eye Specialist			
Hearing Specialist			
Otorhinolaryngologist (ENT)			
Psychiatrist			
Psychologist			
Nutritionist/Dietician			
Occupational Therapist			
Physical Therapist			
Speech Language Therapist			

Type of Service Provider	Agency/Provider Name	Agency/Provider Address	Date(s) Seen
Social Worker			
Children's Rehab. Services			
Public Health Department			
Dept. of Human Resources			
Mental Health Center			
Others specify			

Schools Attended	Address	Date (year) Attended

Evaluations may be required on separate days. Would you have transportation problems or other difficulties in keeping appointments? Yes _____ No_____If yes, please explain. _____

If you have a photograph of your child, please attach. (This photograph will be kept as a part of your child's Sparks chart and will not be returned).

UAB CIVITAN-SPARKS CLINICS
CONSENT FOR SERVICES AND AUTHORIZATION
TO PROCESS INSURANCE CLAIM

Name: _____ Date of Birth: _____
Parents or legal guardian: _____
Address: _____
Street City State Zip County

As the natural parent or legal guardian, I hereby give my permission and consent to the Civitan-Sparks Clinics staff to conduct physical, psychological, and educational examinations on the client and to perform or secure any additional studies associated with, or required for these examinations.

I authorize the Civitan-Sparks Clinics and the members of the professional staff to permit observers (in the room or separated by screens or partitions) of the client and myself during interviews, testing, and examinations. Observers will consider any information revealed during such examinations as confidential.

I authorize the staff to take still photographs of the client. These shall be utilized for client records.

At all times, I retain the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to the Civitan-Sparks Clinics in writing. The revocation shall be effective *except* to the extent that the Civitan-Sparks Clinics has already used or disclosed information in reliance on the Authorization.

I acknowledge this authorization is effective until written notification of revocation is supplied by me.

_____ _____
Mother's signature Date

_____ _____
Father's signature Date

_____ _____
Legal Guardian's signature (if different from parents) Date

_____ _____
Patient's signature (if 14 years old or older) Date

Release of Medical Information

I authorize the release of any/all medical information necessary to process a claim with my insurance carrier.

I acknowledge my right to revoke this authorization at any time by notifying the Civitan-Sparks Clinics Entity Privacy Coordinator in writing: Fred Biasini, 1720 2nd Avenue South, CH19 307, Birmingham, AL, 35294-2041, phone 205.934.5471. I further acknowledge that the revocation shall be effective except to the extent that information has been used or disclosed in reliance on this authorization.

Date: _____ Signed: _____

UAB CIVITAN-SPARKS CLINICS
HEALTH INSURANCE INFORMATION

The Civitan-Sparks Clinics will bill the insurance company directly. The following information is requested for billing purposes. When required, pre-authorization forms must be received prior to appointment date.

Child's Name: _____
Child's Social Security Number: _____
Name of Responsible Party: _____
Primary Insured:
Name: _____
Address: _____
Social Security: _____ Date of Birth: _____
Sex: _____Male _____Female
Patient's relationship to the Primary Insured: _____
Name of Primary Insurance Company: _____
Policy Number: _____ Group #: _____
Secondary Insured:
Name: _____
Address: _____
Street City State Zip
Social Security: _____ Date of Birth: _____
Sex: _____Male _____Female
Patient's relationship to the Secondary Insured: _____
Name of Secondary Insurance Company: _____
Policy Number: _____ Group #: _____

_____ No Medical Insurance
_____ Medicaid # _____
_____ Medicaid # _____

If you are receiving TANF/Public Assistance, SSI and/or are Medicaid eligible, please list your complete 13-digit Medicaid number and name as it is shown on the card.

AUTHORIZATION TO PAY BENEFITS

I understand the following authorization is to be used to effect the collection of benefits in my behalf. This authorization becomes effective on the date of the first service rendered in my behalf. Copies of this agreement will be as valid as this original.

I hereby authorize payment to the Civitan-Sparks Clinics health professionals the benefits payable under all designated health insurance plans, not to exceed the professional's regular charges for periods of evaluation or treatment. I further understand that I am responsible for any co-payment, co-insurance or deductible amounts associated with the visit.

I acknowledge this authorization is effective only until written notification of revocation is supplied by me.

Date: _____ Signed: _____

UAB CIVITAN-SPARKS CLINICS
FINANCIAL STATUS FORM

Please print all entries:

Child's Name:_____
Last First Middle

List all members of client's family in household, including client:

	Name	Age
Head of Household	_____	_____
Spouse	_____	_____
Children	_____	_____
or	_____	_____
Dependents	_____	_____

Own Home _____ Rent _____ Amount per month _____

Please check family income and resources from any of these sources and list the amount you receive from each (list wages/amounts before taxes are taken).

( ) Wages/Salary $_____
( ) Child Support/Alimony $_____
( ) Military Family Allotments $_____
( ) Farmer/Self Employment $_____
( ) Pensions $_____
( ) Tips/Interest $_____
( ) Rents/Dividends $_____
( ) Women, Infant, and Children (WIC) vouchers
( ) Temporary Aid to Needy Families (TANF/ public assistance) $_____
( ) Social Security/Supplemental Security Income (SSI) $_____
( ) Veteran's Benefits $_____
( ) Workman's Compensation $
( ) Unemployment Compensation $_____
( ) Public Assistance $_____
( ) Commission $_____
( ) Support from Family/Friends $_____
( ) Food Stamps $_____

(For phone intake only) Form Verified? _____

Revised January 05
July 06
July 08