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		Mother's Side		Relationship to child (Parent, sibling grandparent, aunt, uncle, cousin)
	Yes	No	Yes	No	
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 fedBreast 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 $______________________
( ) Veteran's Benefits $____________
( ) Workman's Compensation $
( ) Unemployment Compensation $____
( ) Public Assistance $____________
( ) Commission $____________
( ) Support from Family/Friends $_____
( ) Food Stamps $________
( ) Women, Infant, and Children (WIC) vouchers
( ) Temporary Aid to Needy Families (TANF/ public assistance) $______
( ) Social Security/Supplemental Security Income (SSI) $____________

(For phone intake only) Form Verified? ____________________

Revised January 05
July 06
July 08

CSBS DP Communication and Symbolic Behavior Scales Developmental Profile

Infant-Toddler Checklist

Child's name: ______________________ Date of birth: __________

Filled out by: ______________________ Date filled out: __________

Instructions for Caregivers: This checklist is designed to identify different aspects of development in infants and toddlers. Many behaviors that develop before children talk may indicate whether or not a child will have difficulty learning to talk. This checklist should be completed by a caregiver when the child is between **6 and 24 months of age** to determine whether a referral for an evaluation is needed. The caregiver may be either a parent or other person who nurtures the child daily. Please check all the choices that best describe your child's behavior. If you are not sure, please choose the closest response based on your experience. **Children at your child's age are not necessarily expected to use all the behaviors listed.**

Emotion and Eye Gaze

1. Do you know when your child is happy and when your child is upset? ☐ Not Yet ☐ Sometimes ☐ Often
2. When your child plays with toys, does he/she look at you to see if you are watching? ☐ Not Yet ☐ Sometimes ☐ Often
3. Does your child smile or laugh while looking at you? ☐ Not Yet ☐ Sometimes ☐ Often
4. When you look at and point to a toy across the room, does your child look at it? ☐ Not Yet ☐ Sometimes ☐ Often

Communication

5. Does your child let you know that he/she needs help or wants an object out of reach? ☐ Not Yet ☐ Sometimes ☐ Often
6. When you are not paying attention to your child, does he/she try to get your attention? ☐ Not Yet ☐ Sometimes ☐ Often
7. Does your child do things just to get you to laugh? ☐ Not Yet ☐ Sometimes ☐ Often
8. Does your child try to get you to notice interesting objects—just to get you to look at the objects, not to get you to do anything with them? ☐ Not Yet ☐ Sometimes ☐ Often

Gestures

9. Does your child pick up objects and give them to you? ☐ Not Yet ☐ Sometimes ☐ Often
10. Does your child show objects to you without giving you the object? ☐ Not Yet ☐ Sometimes ☐ Often
11. Does your child wave to greet people? ☐ Not Yet ☐ Sometimes ☐ Often
12. Does your child point to objects? ☐ Not Yet ☐ Sometimes ☐ Often
13. Does your child nod his/her head to indicate yes? ☐ Not Yet ☐ Sometimes ☐ Often

Sounds

14. Does your child use sounds or words to get attention or help? ☐ Not Yet ☐ Sometimes ☐ Often
15. Does your child string sounds together, such as uh oh, mama, gaga, bye bye, bada? ☐ Not Yet ☐ Sometimes ☐ Often
16. About how many of the following consonant sounds does your child use: ma, na, ba, da, ga, wa, la, ya, sa, sha? ☐ None ☐ 1–2 ☐ 3–4 ☐ 5–8 ☐ over 8

Words

17. About how many different words does your child use meaningfully that you recognize (such as baba for bottle; gaggie for doggie)? ☐ None ☐ 1–3 ☐ 4–10 ☐ 11–30 ☐ over 30
18. Does your child put two words together (such as more cookie; bye-bye daddy)? ☐ Not Yet ☐ Sometimes ☐ Often

Understanding

19. When you call your child's name, does he/she respond by looking or turning toward you? ☐ Not Yet ☐ Sometimes ☐ Often
20. About how many different words or phrases does your child understand without gestures? For example, if you say "where's your tummy," "where's daddy," "give me the ball," or "come here," without showing or pointing, your child will respond appropriately. ☐ None ☐ 1–3 ☐ 4–10 ☐ 11–30 ☐ over 30

Object Use

21. Does your child show interest in playing with a variety of objects? ☐ Not Yet ☐ Sometimes ☐ Often
22. About how many of the following objects does your child use appropriately: cup, bottle, bowl, spoon, comb or brush, toothbrush, washcloth, ball, toy vehicle, toy telephone? ☐ None ☐ 1–2 ☐ 3–4 ☐ 5–8 ☐ over 8
23. About how many blocks (or rings) does your child stack? **Stacks** ☐ None ☐ 2 blocks ☐ 3-4 blocks ☐ 5 or more
24. Does your child pretend to play with toys (such as feed a stuffed animal, put a doll to sleep, put an animal figure in a vehicle)? ☐ Not Yet ☐ Sometimes ☐ Often

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For ordering information on all components of the CSBS DP, visit www.brookespublishing.com/csbs.

www.m-chat.org

Child's name ______________________ Date ______________________

Age ______________________ Relationship to child ______________________

M-CHAT-R™ *(Modified Checklist for Autism in Toddlers Revised)*

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

Question		
1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

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