



Parent/Caregiver Intake Information Form
Lower Shore Early Intervention Program (LSEIP)

I. Information

Parent(s) Name(s): _____ Child's Name: _____

Child's Date of Birth: _____ Child's age in months: _____ Gender: Male Female

Family's Ethnic Background: African American White Hispanic American India/Alaskan Native
 Asian/ Pacific Islander Other: _____

Primary language in the home: English Spanish Other: _____

Home Address: _____

Parent Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Email Address: _____

Time at current address: _____ years _____ months County: _____

Military What school district are you currently in? _____

Who has legal custody? Mother Father Shared custody Other (Foster Home, Relative, etc.) _____

Adults in the home: Two biological parents Shared custody Mother alone Father alone Adopted
 Foster parent(s) Mother with partner Father with partner Other _____

No. of siblings, name, & Ages: _____

Child's age at entry into Child Care: _____ years _____ months

Has the child been in other child care center(s) or family child care home(s)? Yes No

If yes, please list different placements and how long the child was at each placement: _____

Current Child Care Center/Caregiver Name: _____

Facility Type: Home Provider Center Informal Pre K-12 Early/Head Start

Address: _____ Phone: _____

II. Concerns

What is the (1) primary, (2) secondary, (3) tertiary concern? Aggression Attention Anxiety Disruption
 Hyperactivity Pica (eating non-edible items) Seems Depressed Self Injury Withdrawn
 Somatic (excessive complaints of physical ailments) Other _____

When did behavioral difficulties begin? _____

Are there any significant changes in the child's life? If yes, please describe what and when: _____

Does the child have a diagnosis or diagnoses? Yes No

- | | | |
|---|--|---|
| <input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder | <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Speech and Language Delay | <input type="checkbox"/> Cognitive Delay | <input type="checkbox"/> Developmental Delay |
| <input type="checkbox"/> Sensory Impairment | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Other : _____ |

Does the child have an IEP or IFSP? Yes No

III. Other Participation in Programs

Is the child attending any other programs or receiving other services? Yes No

If yes, please specify: Infants & Toddlers Child Find Other _____

Do you currently participate in Child Care Subsidy (formerly Purchase of Care)? Yes No

Is the child or family receiving services from Department of Social Services? Yes No

If yes, which services? _____ Name of Worker _____

IV. General Developmental:

Was the child born Full term or Prematurely? How premature? _____ Birth Weight _____ lbs _____ oz

Any concerns about child’s motor skills (i.e. walking, sitting, crawling)? Yes No

Does the child have any speech problems? Yes No

Does the child have any medical problems? Yes No

Asthma Allergies to Medicines Seizure Seasonal Allergies

Other _____

Has hearing been checked recently? Yes No If yes, when? _____

Has eye sight been checked recently? Yes No If yes, when? _____

How does the child communicate? (i.e. babble, point, words) Example: _____

How many words does the child use? _____

Does the child put words together? (2 – 3 word sentences) Yes No

Does the child make any sounds? (i.e. car sounds, animal sounds) Yes No

Example: _____

Does child understand simple directions? (e.g. “Put that down;” “Get your coat.”) Yes No

Name of Pediatrician and/or other doctor/specialist _____

Pediatrician Phone Number: _____ Specialist Phone Number: _____

Date of last visit: _____ Are immunizations up to date? Yes No

Insurance: _____

V. Consent Agreement

I give permission for the Lower Shore Early Intervention Project to use the information provided on this form to assist in identifying my child’s needs. I understand this also includes any preliminary evaluations/screens used to assess my child. I understand that this information will be kept completely confidential. I also understand that positive results are contingent upon consistent implementation of the recommended strategies. I am aware that I may request information to be removed from my child’s file if it is inaccurate, misleading, or otherwise in violation of the privacy or other rights of my child. I am also aware that I may request a copy of this completed form for my own records.

Name of Parent/Guardian Date: _____

Signature of Parent/Guardian Date: _____

Signature of Provider/Other Date: _____