CARING STRATEGIES
Center for Child Development & Pediatric Therapies

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Child Intake Form

Date of Intake: _____

Child's Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

Address: _____

Cell Phone: _____ **Email:** _____

Child's Primary Care Physician: _____

Child's School/Daycare: _____ **Grade:** _____

Referred to our center by: _____

Emergency Contact: _____

Phone Number: _____ **Relationship to Child:** _____

Is there any history of speech, language, hearing, feeding problems, learning issues or delays in other family members? _____

Diagnosis (Please indicate any medical diagnosis or medical condition below):

Main Concerns:

Personal Goals: