

**The James L. Dennis Developmental Center
1301 Wolfe Street
Little Rock, Arkansas 72202**

**Clinic Telephone Number: (501) 364-1830
Fax: (501) 364-4967**

INTAKE REQUEST (Part 2: Parent/Guardian)

Date of Request _____

PATIENT NAME _____
Last
First
Middle

Patient Date of Birth:	Age:	Sex:	Race:
Patient Street Address:			
Patient Town/City:	Zip Code:	County:	
Home Telephone: (Include Area Code)		Cell Phone:	
Best phone number to contact you Mon-Fri between 9A and 3P:			
Parents or Legal Guardian of Patient:			
Work Telephone:		Message Telephone:	
Primary Care Physician (PCP):			
PCP Telephone:		PCP Office location (town):	
School Child Attends:		Grade:	
What is the primary language spoken in the home?			

Is this appointment a first time visit or a follow up visit to the DDC?

First Time Visit
 Follow-up Visit (**For Medical** **For Testing**)

PLEASE NOTE: The *Dennis Developmental Center* specializes in the assessment of developmental conditions that result in delayed milestones, inability to communicate effectively, inattention, hyperactivity, impulsivity, learning problems, and poor or atypical social interactions. Evaluation and therapy are also provided for families coping with the stress of chronic developmental disorders or chronic medical illnesses, and with grief and loss concerns. ***Please refer your patient to the Child and Adolescent Psychiatric Division (Child Study Center at 501-364-5150) at Arkansas Children's Hospital or your local mental health agency for diagnosis or treatment of disorders that are primarily psychiatric (i.e., bipolar disorder, anxiety disorders, oppositional defiant disorder, conduct disorder, personality disorders, etc.) or issues related to child abuse or custody.***

What do you think are your child's main problems? _____

What have you been told by doctors, teachers, or others about your child's problems? _____

What questions do you want answered from your child's Dennis Developmental Center evaluation?

Has your child ever had testing to evaluate for learning or developmental problems? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, when was testing done?	Where was testing done?
Please indicate any services your child currently receives:	
<input type="checkbox"/> Early Childhood Developmental Services	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Self-Contained Classes	<input type="checkbox"/> Title I
<input type="checkbox"/> Resource (i.e., special education) Classes	<input type="checkbox"/> Counseling
<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> 504 Modifications
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other: _____
Serious illnesses or major medical problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes please list problems:
Vision Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes
Has the child previously received mental health diagnosis or treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes please list:	
Does this child take any medications on a regular basis? <input type="checkbox"/> No <input type="checkbox"/> Yes please list:	
Comments: Is there anything else you would like us to know about the child? 	

Form completed by: _____