DAVIES INSTITUTE
FOR SPEECH & HEARING

General Intake Form

Child Information

Date Form Completed: _____

Child's Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City/State/Zip Code: _____

Primary Care Physician (PCP): _____

PCP Phone: _____ Date Last Seen: _____

Parent 1

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip Code: _____

Occupation: _____ E-mail: _____

Primary Phone: _____ Secondary Phone: _____

Parent 2

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip Code: _____

Occupation: _____ E-mail: _____

Primary Phone: _____ Secondary Phone: _____

Circle the ways we may communicate with you: Phone Text Message E-mail

Circle if we may we leave a message at: Primary Phone Secondary Phone E-mail

Other Family Members Living with Child:

Name:	Age:	Gender:	Grade:	School:	Special Education Needs?

Prenatal and Birth History

Describe any illnesses, conditions, or accidents during the pregnancy (i.e. German measles, RH Incompatibility, etc.)

_____

_____

Was any medication taken during pregnancy? If yes, please describe.

_____

_____

Length of Pregnancy: _____ Length of Labor: _____ Birth Weight: _____

Describe any problems during the delivery (i.e. breech birth, induced labor, shoulder dystocia, etc.).

_____

_____

Medical History

Child's Present Weight _____ Child's Present Height _____

Does your child have any history of the following illnesses or conditions? If so, please provide the approximate age that they first were first diagnosed.

Asthma	_____	Flu	_____	Seizures	_____
Bronchitis	_____	Headaches	_____	Sinusitis	_____
Chicken Pox	_____	High Fever	_____	Sore Throat	_____
Convulsions	_____	Mastoiditis	_____	Tinnitus	_____
Croup	_____	Measles	_____	Tonsillitis	_____
Dizziness	_____	Meningitis	_____	Other	_____
Ear Infections	_____	Mumps	_____		_____
Encephalitis	_____	Pneumonia	_____		_____

Does your child have any history of allergies? If so, what allergies do they have and what is the reaction (i.e. runny nose, rash, hives)

_____

_____

Does your child receive any medications currently? If so, please list them.

_____

_____

Has your child had any surgeries? If yes, please provide age(s) and description(s). _____

_____

_____

Privacy and Consent Form

PERMISSION TO EVALUATE:

I hereby authorize the evaluation of my/my child by the providers of Davies Institute, LLC., for the services pertaining to educational diagnostics, audiology, speech therapy, and/or occupational therapy services.

Signature:_____ **Date**:_____

PERMISSION FOR RELEASE OF RECORDS:

I hereby authorize the release of my/my child's records from Davies Institute, LLC., to be released to the following persons with my full consent: (i.e. relative, family physician, etc.)

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Signature:_____ **Date**:_____

PERMISSION TO OBTAIN RECORDS:

I hereby authorize Davies Institute, LLC., to obtain my/child's records from the following persons with my full consent: (i.e. relative, family physician, etc.)

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Signature:_____ **Date**:_____

RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICES:

A copy of our Notice of Privacy Practices is displayed on the wall next to our front desk. If you prefer a written copy one will be made available to you upon request.

Signature:_____ **Date**:_____

PERMISSION TO PHOTOGRAPH:

I hereby give Davies Institute, LLC. Permission to take pictures of me/my child for the following professional use:

- Use to update parents on the Brightwheel app (DISH School only)
- Use on commercial marketing products (i.e. brochures, flyers, website)
- Use on social media (i.e. Facebook, Instagram, LinkedIn)

Signature:_____ **Date**:_____