

SERVICES FOR THE DEVELOPMENTALLY CHALLENGED
5475 FIELDSTON ROAD
BRONX, N.Y 10471
718-432-8469
718-432-8546 Fax

Intake Sheet

Fields marked with an asterisk are required.

| | | | |
|---|--------------------|---|-------------|
| *Last Name | *First Name | Initial | |
| *Address <hr/> <hr/> | | | |
| *Phone # | Phone # | D.O.B. | Sex |
| Diagnosis/ Documentation | | | |
| *Mother's /Caregiver's Name | | Father's/Caregiver's Name | |
| Siblings/Other Family Members | | | |
| Medical Provider's <hr/> <hr/> <hr/> | | | |
| Asthma Yes or No | | Seizures Yes or No | |
| Medications | | Known Allergies | |
| Programs/School/Agencies Involved <hr/> <hr/> <hr/> | | Programs/School/Agencies Involved <hr/> <hr/> <hr/> | |
| Notes | | | |
| *Person Completing Form | | | Date |