CHILDREN'S DEVELOPMENTAL CENTER

REVISED 4/19/21

ENROLLMENT INTAKE FORM

Child's Name_____ Date of Birth_____

I learned about the CDC from: _____ACBDD Early Intervention _____LMH Therapy Department

_____Former CDC family _____Other (please list)_____

FAMILY:

Child resides with_____

Other Children in the home	Birthdate	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there any family medical history that would be helpful in the treatment of your child? ____YES ____NO

(if yes please explain)

MEDICAL:

Any complication with the pregnancy or delivery? ____YES ____NO

(if yes please explain)

If born premature please indicate the number of weeks_____

Any diagnosis or chronic health conditions we need to be aware of:

_____

Allergies (seasonal, medication, food etc)_____

Current Physicians/Specialists treating your child regularly:

Name/Location_____

Name/Location_____

Name/Location_____

Adaptive Equipment currently being used by your child:

Glasses____ braces_____ hearing aid_____ walker_____ wheelchair_____ helmet_____ other_____

DEVELOMENTAL MILESTONES:

Approximate Age for the milestones that your child has demonstrated to date:

Smiled_____ rolled_____ sat without support_____

Crawled_____ finger feed_____ stood with support_____

Walked without assist_____ spoke first word_____ spoke in phrases_____

Used spoon to self-feed_____ potty trained_____

FEEDING:

Please list preferred foods_____

Current method of drink: (bottle, sip cup, straw, open cup)_____

Utensils that your child can use independently: spoon_____ fork_____

Does your child have difficulty swallowing or chewing food? Yes_____ No_____

Feeding concerns you want staff to be aware of:

DAILY ROUTINES:

Does your child sleep through the night?_____

Average number of hours slept each night_____

Nap schedule_____

Normal Bed time for your child_____

Does your child have a television in their bedroom?_____

Approximate amount of time that your child interacts with electronic devices daily (tv, cell phones, game systems etc)_____

Does your child regularly interact with other children?_____

What calms your child_____

How is discipline used with your child?_____

SELF REGULATION:

Circle all of the self regulation/behaviors below that apply to your child:

ABLE TO CALM TOUCHES ALL TEXTURES RECOVERS FROM ANGER

PLAYS WITH TOYS APPROPRIATELY ENGAGES IN PRETEND PLAY USES WORDS TO COMMUNICATE

FOLLOWS RULES REMAINS FOCUSED REALIZES HOW BEHAVIOR RELATES TO CONSEQUENCES

INTERACTS IN A SOCIALLY APPROPRIATE MANNER

SUPPORT SERVICES:

Please indicate all services your child will receive while attending CDC:

Therapy Services through Lima Memorial ____Speech ____OT ____PT

Therapy Service through another provider ____Speech ____OT ____PT

Please list the therapy provider_____

Attending additional preschool program _____ Name of program and schedule_____

_____Additional specialists will be providing services at the CDC while my child is in attendance

Services that will be provided: _____speech ____OT ____PT ____Itinerant Teacher

COMMUNICATION:

Do you use sign language with your child _____yes ____no

Please list signs that your child is currently using or that you encouraging at home:

GOALS AND CONCERNS YOU HAVE FOR YOUR CHILD: