

Intake Form

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PLEASE PRINT

Patient's Name:	_____	Birthdate:	____/____/____
	First MI Last		Month Day Year
Home Address:	_____	_____	_____
	Street	City	State Zipcode
Billing Address:	_____	_____	_____
(if different from above)	Street	City	State Zipcode
Home Phone:	_____ - _____	Parent's email:	_____
Cell Phone:	_____ - _____		
Mother's Name:	_____	_____	_____
Please circle: Ms. Mrs. Dr.	Employer	Business Phone	
Home Address:	_____	_____	_____
(if different from above)	Street	City	State Zipcode
Father's Name:	_____	_____	_____
Please circle: Mr. Dr.	Employer	Business Phone	
Home Address:	_____	_____	_____
(if different from above)	Street	City	State Zipcode

School: _____ Grade: _____

Referred by: _____

Physician/ Pediatrician: _____

Current Medications: _____

Birth & Medical History: _____

Age of Developmental Milestones: _____
Sitting Walking First Words

Food Allergies: _____

Previous Testing or Treatment: _____

Reason for Visit: _____

Do we have permission to take a picture of your child for our records only? YES NO

Send additional report to: (optional)

Name	Street	City	State	Zipcode	Fax #
Name	Street	City	State	Zipcode	Fax #