**CHILD INFORMATION**

|  |  |  |
| --- | --- | --- |
| Today’s Date: | Child’s Name: | Gender: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age: | Birthdate: | Height: | Weight: | Diagnosing Physician:  Phone/Fax:  Diagnosis Given:  Date of Diagnosis: |
| Referred By:  Specialty: | | Primary Care Physician:  Phone/Fax: | |

**CHILD’S CURRENT LIVING SITUATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Tell us about all of the caregivers that your child currently lives with *(e.g., biological mother, adoptive father, grandmother).*  Describe: | | | | | |
| Please provide information on who your child **currently** lives with below: | | | | | |
| **Parent/Caregiver 1** | | | **Parent/Caregiver 2** | | |
| Name: | | Age: | Name: | | Age: |
| Occupation: | | | Occupation: | | |
| Ethnic/Cultural Background: | | | Ethnic/Cultural Background: | | |
| Home Phone: | Cell Phone: | | Home Phone: | Cell Phone: | |
| Work Phone: | Email: | | Work Phone: | Email: | |
| Highest Level of Education: | | | Highest Level of Education: | | |
| If your child **does not live with both biological parents**, who has legal custody of the child?  *(Please provide copies of the custody agreement).* | | | | | |
| Name: | | | Relationship to Child: | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Tell us about your child’s **siblings:** *(Please list all siblings, whether or not they live with your child)* | | | | |
| Name: | Age: | Gender: | Full/Step/Half? | Lives w/ Child?  **O** yes **O** no |
| Name: | Age: | Gender: | Full/Step/Half? | Lives w/ Child?  **O** yes **O** no |
| Name: | Age: | Gender: | Full/Step/Half? | Lives w/ Child?  **O** yes **O** no |
| Name: | Age: | Gender: | Full/Step/Half? | Lives w/ Child?  **O** yes **O** no |

|  |  |
| --- | --- |
| Tell us about the **languages** used in home. | |
| What languages does the child use (List PRIMARY language first):  1.  2. | What other languages is your child exposed to?  1.  2. |

**PRENATAL/PREGNANCY/BIRTH**

|  |  |
| --- | --- |
| Tell us about the **birth/biological mother**. | |
| Age at conception: | Assisted reproduction? **O** yes **O** no  Describe: |

|  |  |
| --- | --- |
| Did the **birth/biological mother** have any of the following medical problems before/during/after pregnancy? | |
| Maternity difficulties (pre, peri, and/or post). **O** yes **O** no  Describe: | |
| Maternal hospitalization (pre, peri, and/or post). **O** yes **O** no  Reason: | |
| Maternal emotional and/or physical complications (pre, peri, and/or post). **O** yes **O** no  Describe: | |
| Exposure to illicit drugs during pregnancy (including marijuana).  **O** yes **O** no  1.  2.  3. | Maternal medications/supplements during pregnancy.  **O** yes **O** no  1.  2.  3. |
| Exposure to alcohol: **O** yes **O** no | |

|  |  |  |  |
| --- | --- | --- | --- |
| Tell us about the **delivery.** | | | |
| Was your child born full-term? **O** yes **O** no | Birth Weight: | If premature, how early? | If overdue, how late? |
| Check all that applied to the **delivery.** | | | |
| **O** Spontaneous **O** Breach  **O** Forceps **O** Head first  **O** Multiple births **O** Cord around neck  **O** Other: | | **O** Induced. Reason: | |
| **O** Cesarean. Reason: | |
| Which of the following applied to the **infant**? Check all that applied. | | | |
| **O** Breathing problems **O** Sleeping problems **O** Jaundice; Bilirubin lights used?  **O** Feeding problems **O** Excessive crying **O** Unusual appearance? Describe:  **O** Rash **O** Seizure/convulsions **O** Other: | | | |

**DEVELOPMENTAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| During your child’s **first three years**, tell us if you observed any of the following. | | | |
| **O** irritability **O** breathing problems **O** colic  **O** difficulty sleeping **O** eating problems **O** temper tantrums  **O** failure to thrive **O** excessive crying **O** withdrawn behavior  **O** poor eye contact **O** early learning problems **O** destructive behavior  **O** convulsions/seizures **O** twitching **O** unable to separate from parent  **O** other: | | | |
| Has your child ever lost skills? *(e.g., words, eye contact).* **O** yes **O** no  Describe: *(what skills, what age)* | | | |
| Answerthe following about your child’s **language development.**  At what age did your child begin to: | | |
| **Skill** | **Currently Needs Assistance** | **Age Mastered *(e.g., 18 months)*** |
| Babble | **O** |  |
| Use single words | **O** |  |
| Use phrases (2 words) | **O** |  |
| Use short sentences (3-4 words) | **O** |  |
| Use longer sentences (5+ words) | **O** |  |
| Answer the following about your child’s **motor development.** | | |
| Roll Over | **O** |  |
| Sit unaided | **O** |  |
| Crawl | **O** |  |
| Stand up | **O** |  |
| Walk unaided | **O** |  |
| Answer the following about your child’s **self-help skills.** | | |
| Toileting for urination *(day)* | **O** |  |
| Toileting for urination *(day and night)* | **O** |  |
| Toileting for bowel movements *(day)* | **O** |  |
| Toileting for bowel movements  *(day and night)* | **O** |  |
| Washes hands | **O** |  |
| Brushes teeth | **O** |  |
| Sits for meals | **O** |  |
| Feed self | **O** |  |
| Uses eating utensils *(e.g., fork, spoon)* | **O** |  |
| Drinks from open cup | **O** |  |
| Uses a straw to drink | **O** |  |

**MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Tell us if your child has experienced any of the following. | | |
| **Type** | **Age** | **Describe** |
| Head injury |  |  |
| Loss of consciousness |  | *(include duration)* |
| Hospitalization |  | *(include reason)* |
| Surgery |  |  |
| Infections (e.g., ear) |  |  |
| Other: |  |  |
| Other: |  |  |
| Other: |  |  |
| Other: |  |  |

|  |  |  |
| --- | --- | --- |
| Tell us about your child’s **allergies.** *(You may also attach a document if easier.)* | | |
| Food Allergies *(not sensitivities):*  **O** yes **O** no  List: | Medication Allergies:  **O** yes **O** no  List: | Environmental Allergies:  **O** yes **O** no  List: |

|  |
| --- |
| Tell us about your child’s **immunizations.** *(Immunization records should be submitted before admission.)* |
| Is your child up to date on immunizations? **O** yes **O** no  If no, why not? |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please tell us about the **physicians** your child has seen. | | | | |
| Type | Name | Email and Phone | Diagnosis/Results | Last Visit Date |
| Pediatrician/  Behavioral Pediatrician |  |  |  |  |
| Psychiatrist |  |  |  |  |
| Psychologist |  |  |  |  |
| Geneticist |  |  |  |  |
| Neurologist |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Please tell us about your child’s history of **medical testing.** | | |
| **Type** | **Date of Test** | **Results** |
| EEG |  |  |
| MRI |  |  |
| CT Scan |  |  |
| Hearing |  |  |
| Ophthalmology |  |  |
| Genetic  **O** Buccal swab  **O** Whole exome  **O** Other: |  |  |
| Other: |  |  |
| Other: |  |  |
| Other: |  |  |
| Other: |  |  |
| Other: |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please tell us about your child’s **medication history.** Begin with **current** medications. *(You may also attach a document if easier.)* | | | | | |
| **Name of Medication** | **Prescribing Physician** | **Dose Range and Frequency** | **Date Started and Ended** | **Reason for Ending** | **Current or Past** |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please tell us about your child’s **supplement/vitamin history.** Begin with **current** supplements.  *(You may also attach a document if easier.)* | | | | | |
| **Name of Supplement** | **Prescribing Physician** | **Dose Range and Frequency** | **Date Started and Ended** | **Reason for Ending** | **Current or Past** |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |
|  |  |  |  |  | **O** Current  **O** Past |

**CURRENT CONCERNS ABOUT YOUR CHILD**

|  |  |  |  |
| --- | --- | --- | --- |
| Tell us about your **current concerns** about your child. | | | |
| **Related to behaviors:**  **O** does not follow directions/ noncompliance  **O** difficult transitions  **O** sometimes seems “spacey”  **O** poor sustained attention  **O** fearful or anxious  **O** temper tantrums  **O** self-injury  **O** aggression  **O** self-stimulatory behaviors  **O** rigidities/ritualistic behaviors  **O** preoccupations  **O** unsafe behavior  **O** impulsive behavior  **O** hyperactive behavior | **Related to social skills:**  **O** plays alone  **O** peer relationships  **O** adult relationships  **O** toy play  **O** recreational play  **Related to self help skills:**  **O** urine/bm training  **O** toileting  **O** washing hands  **O** food selectivity  **O** meal related skills  **O** sleep problems  **O** dressing skills | **Related to speech and language skills:**  **O** speech/articulation  **O** AAC devices  **O** spontaneous initiations  **O** prompted language  **O** reciprocal conversations  **Other Skills:**  **O** cognitive skills  **O** academic skills  **O** fine motor skills  **O** gross motor skills | **Related to services:**  **O**  school  **O** regional center  **O** IHSS  **O** respite  **O** medical  **O** resources  **Related to medical:**  **O** diagnostic clarification  **O** hearing  **O** medication  **O** referrals to medical specialists (neuro, geneticist) |

|  |  |
| --- | --- |
| Please answer the following questions about your child. | |
| Can your child be described as clumsy/uncoordinated? **O** yes **O** no  Does your child have a fine motor delay? **O** yes **O** no  Does your child have a gross motor delay? **O** yes **O** no  Does your child have a dominant hand? **O** yes **O** no If so, which hand: **O** Left **O** Right | |
| What is your child’s current eating behavior?  **O** normal **O** overeats  **O** picky **O** over stuff  **O** weight loss/gain | Do you have any oral motor concerns?  **O** none **O** difficulty swallowing  **O** drooling **O** gagging |
| Is your child on a special diet?  **O** yes **O** no  Describe: | Do you have concerns about your child’s food repertoire?  **O** yes **O** no  Describe: |

|  |  |  |
| --- | --- | --- |
| Tell us of any recent **major stressors** on the family or your child, experienced within the last year. | | |
| **O** marital discord/fighting  **O** birth/adoption of another child  **O** custody disagreement  **O** parent deployment  **O** abandonment by a parent  **O** child neglect  **O** parental disagreement about  child rearing | **O** separation  **O** divorce  **O** sibling conflict  **O** single parent family  **O** parent’s mental health concerns  **O** parent’s substance abuse  **O** financial problems  **O** physical abuse | **O** parent-child conflict  **O** death in the family  **O** involvement in juvenile court  **O** involvement with social services/child protective services  **O** sexual abuse  **O** other: |

|  |  |
| --- | --- |
| Tell us about your **family supports.** | |
| **O** belong to parent support group  **O** belong to sibling support group | **O** have a religious/cultural affiliation  List: |

**REGIONAL CENTER FUNDED SERVICES**

|  |  |  |
| --- | --- | --- |
| Answer the following questions about your **Regional Center.** | | |
| Is your child currently a client of a Regional Center?  **O** yes **O** no | | Name of Regional Center: |
| **O** Early intervention unit (up to age 3 years)  **O** School age unit (3 years and above) | | Name of Service Coordinator:  Phone & Email: |
| Age when child was accepted as client: | Date when RC services began: | Age when Regional Center services began: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please tell us about your **current** Regional Center Services | | | | | |
| **Type** | **Individual hours/wk** | **Group hours/wk** | **Provider name** | **Email & Phone** | **Start date** |
| Infant Stimulation/ Early Intervention |  |  |  |  |  |
| Speech Therapy |  |  |  |  |  |
| Occupational Therapy |  |  |  |  |  |
| Physical Therapy |  |  |  |  |  |
| Social Skills/Group |  |  |  |  |  |
| Recreation Therapy |  |  |  |  |  |
| Behavioral Therapy  **O** home based  **O** center based |  |  |  |  |  |
| Other (list): |  |  |  |  |  |
| Other (list): |  |  |  |  |  |

**SCHOOL BASED SERVICES**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Please **list all schools/programs** your child has attended, beginning with the **current** school: | | | | | | |
| **Month and**  **Year Started** | **Age Started** | **School Name**  **(Current school first)** | **Type of Class (e.g., general education, autism-specific SDC, preschool mixed)** | **Days, hours per week** | **# Children in class** | **# Adults in class *(including teacher)*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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| --- | --- | --- |
| Answer the following questions about your **Specialized Services.** | | |
| Date of first IEP: | School district: | Special education categorization *(e.g., ASD, Speech or Language Impairment, Other Health Impairment)* |
| Date of most recent IEP: | District contact person: | District contact email & phone: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please tell us about your child’s **current** school based services | | | | | |
| **Type** | **Individual hours/wk** | **Group hours/wk** | **Provider name** | **Email & Phone** | **Start date** |
| Speech Therapy |  |  |  |  |  |
| Occupational Therapy |  |  |  |  |  |
| Adaptive Phys. Education |  |  |  |  |  |
| Physical Therapy |  |  |  |  |  |
| BII/BID Services *(i.e., behavioral aide, in school consultation)* |  |  |  |  |  |
| Resource |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Other (list): |  |  |  |  |  |
| Other (list): |  |  |  |  |  |

**PRIVATE/INSURANCE FUNDED SERVICES**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please tell us about your child’s **current** private/insurance funded services and activities | | | | | |
| **Type** | **Individual hours/wk** | **Group hours/wk** | **Provider name** | **Email & Phone** | **Start date** |
| Behavioral Therapy  **O** home based  **O** center based |  |  |  |  |  |
| Speech Therapy |  |  |  |  |  |
| Occupational Therapy |  |  |  |  |  |
| Physical Therapy |  |  |  |  |  |
| Other Activities (list): |  |  |  |  |  |
| Other Activities (list): |  |  |  |  |  |
| Other Activities (list): |  |  |  |  |  |
| Other Activities (list): |  |  |  |  |  |
| Other Activities (list): |  |  |  |  |  |

**INSURANCE INFORMATION KIDSCONNECT AUTISM PROGRAM**

PATIENT INFORMATION **UCLA Medical Record #: \_\_\_\_ \_\_\_\_ \_\_\_\_ - \_\_\_\_ \_\_\_\_ - \_\_\_\_ \_\_\_\_**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address (street, city, state, zip code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PARENT INFORMATION:**

Name: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Pt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PRIMARY INSURANCE:**

Medical : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Plan:** \_\_\_\_\_ **Individual or Group** **Self Funded \_\_\_\_\_\_\_\_ HMO Medical Group**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # / Policy # / Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT RESPONSIBLE FOR INSURANCE/PRIMARY PAYOR**

Name: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SECONDARY INSURANCE (If applicable)**

Medical : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Plan:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Individual or Group** **Self Funded HMO Medical Group**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # / Policy # / Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT RESPONSIBLE FOR INSURANCE – SECONDARY PAYOR:** \_\_\_SAME as Guarantor \_\_\_DIFFERENT from Guarantor

Name: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please **EMAIL** copies of your child’s most recent reports and documents, **including**:

Copy of your insurance card, front and back, Regional Center assessments and IFSP – Individual Family Service Plan or IPP – Individual Program Plan, School district assessments and IEP – Individual Educational Plan, Any other relevant reports/evaluations, such as most recent psychological testing, speech and language, OT, neurological, developmental pediatrician, child psychiatrist, etc.

Along with the Patient History Forms, email to:

**Annette Lovato**

Administrative Director

KidsConnect Resnick Neuropsychiatric Hospital at UCLA

760 Westwood Plaza, Room 78-215

Los Angeles, CA 90024

alovato@mednet.ucla.edu