CHILD & FAMILY CONNECTIONS
INTAKE/SOCIAL HISTORY SUMMARY SHEET

Child's Last Name, First Name & Middle Initial: _____

Child's Date of Birth (Month/Date/Year): _____ Date of Intake: _____

Chronological Age (CA): _____ Months _____ Days Adjusted Age (AA): _____ Months _____ Days

CFC #: _____ Name of Service Coordinator: _____

Name of Person Completing Intake: _____

I. REFERRAL INFORMATION REVIEW

Review the reasons(s) for referral with the family member(s): Does the family agree or disagree? Summarize discussion below:

II. OTHER PERSONS RESIDING IN HOUSEHOLD WITH CHILD

Please list all members of child's immediate family and other persons living in the same household and provide the information requested below (also enter this in PA16 in Cornerstone):

Family Member Name	Relationship	Date of Birth	Occupation- Place of Employment/ Grade in School	Other Comments
	Mother			
	Father			

Is there a history of medical or developmental problems in either the mother or father's side of the family that may be important for us to know with respect to your child? ☐ Yes ☐ No

If yes, please explain. _____

III. PRIMARY MEDICAL CARE

Primary Care Physician:	
Physician's Name	*Phone #*
Specialty Physician	*Phone #*
Reason to see specialist and results of visit:	
Specialty Physician	*Phone #*
Reason to see specialist and results of visit:	
Specialty Physician	*Phone #*
Reason to see specialist and results of visit:	
Specialty Physician	*Phone #*

IV. HEALTH HISTORY SINCE BIRTH

How has your child's health been since birth? (include discussion of illnesses, hospitalizations, long-term medications, etc.):	
Prescribed Medications:	**Reason Taken:**
Adaptive Equipment:	**Reason Needed:**

V. SCREENING & ASSESSMENT HISTORY

Please list dates of previous screening, assessments or other tests (including birth and developmental screening, vision and hearing, etc):

Date	*Test Administered*	*By Whom?*	*Results/Comments*
	New Born Hearing Screening		*Passed:* ☐ *Yes* ☐ *No*

Date	*Test Administered*	*By Whom?*	*Results/Comments*
	Additional Hearing Tests		
	Vision		

VI. BIRTH AND PREGNANCY INFORMATION

Please complete the EI20 and PA11 in Cornerstone

VII. RESULTS OF ROUTINE BASED INTERVIEW AND ASQ:SE

STRENGTHS: Objective Observations, Parent Statements About Support Systems, Use of Other Resources, Parent/Child Interaction, Knowledge/Understanding of Child's Needs, etc.

SUPPORTS AND RESOURCES: (List all supports and resources available to the family including childcare (Home, Center or Relative), Extended Family, Church, Community Playgroups, WIC, All Kids/Medicaid, Respite Care, Health Department, etc.)

FAMILY ROUTINES: List Important Family Routines Including Satisfaction and Struggles with those Routines: (NOTE: This should be a Summary of Routines that are most important and have the highest priorities For Each Family. Same routines such as bed or bath time will differ in importance and priority across families).

DEVELOPMENTAL CONCERNS, ISSUES and PRIORITIES: Parental Concerns/Issues identified through conversation/ ASQ:SE/RBI, Objective Statements of SC Observations, Family Priorities as Related to Their Child's Development, etc.

ASQ-SE		**Concerns:** ☐ **Yes** ☐ **No**

Evaluations Needed:	☐ **DT**	☐ **ST**	☐ **PT**	☐ **OT**	☐ **SW**	☐ **Psych**
Other:						