Patient Information

Date:	
Patient Name:	
Date of Birth:	
Address:	
Phone:	
Dominant Language:	English Spanish Other:

Medical Exam

Date of Exam:	

Concern		Comments/Test Results
Seizure Disorder	○ No Concerns ○ Concerns Noted	
Attention Problems	○ No Concerns ○ Concerns Noted	
Sleep Concerns	○ No Concerns ○ Concerns Noted	
Digestive Problems	○ No Concerns ○ Concerns Noted	
Elimination Problems	○ No Concerns ○ Concerns Noted	
Nutrition Concerns	○ No Concerns ○ Concerns Noted	
Depression Concerns	○ No Concerns ○ Concerns Noted	

Concern		Comments/Test Results
Genetic Testing	○ Completed — No Abnormalities ○ Completed — Abnormalities Noted ○ Not Completed — No Concerns ○ Not Completed — Other Reason	
Vision Screen	○ Within Normal Limits ○ Outside Normal Limits	
Audiology Screen	○ Within Normal Limits ○ Outside Normal Limits	
Other Concerns?	○ No Concerns ○ Concerns Noted	

Medication and Dosage:	
Medical Diagnosis and Code:	

Name of Prescribing Provider:	
NPI Number:	

Signed Date

SC Office Tracking ONLY:

Date Received: _____ Intake Date: _____ Initials: _____