Dyslexia Center of Tulsa Intake Form

Date: _____

Parent Information

Parent/Guardian Name: _____
Marital Status: Married Single
Address: _____
City:_____ State:_____ Zip: _____
Phone Number: _____
E-mail: _____
Insurance: __ BCBS __ Sooner Care __ Private Pay (no insurance) __ Other_____
Policy #: _____ Group #: _____
Main Reason for being evaluated: _____
_____

Prenatal History

Full term pregnancy? (40 Weeks)◯Yes◯No If now, how many weeks?_____
Were medication(s) given during pregnancy?◯Yes◯No If yes, what?_____
_____
Did you have any illnesses during pregnancy?◯Yes◯ No If yes, what?_____
_____How many weeks into pregnancy?_____
_____
Were you confined to a bed?◯Yes◯No
Did you have any spotting/bleeding during pregnancy?◯Yes◯No
Did you smoke during pregnancy?◯Yes◯No

Child Information

Child's Name:_____
Age: _____ Date of Birth:_____ Male:__ Female: __
School:_____Grade:_____
Teacher:_____
Physician Name: _____
Physician Phone Number: _____

School History

Has any grade been repeated? ◯ Yes ◯ No If yes, which grade? _____

What were the subjects repeated? _____

Rate your child's current performance in the following subjects:

1 – above average 2 – average 3—below average

__ Reading __ Spelling __ Mathematics

__ Comprehension __ Handwriting __ Letter Formation

__ Keeping numbers lined up when doing math problems

__ Letter Spacing __ Word spacing

Is your child in any special classes? ◯ Yes ◯ No

Has he/she ever been in any special classes? ◯ Yes ◯ No

Which classes? _____

Has your child had tutoring? ◯ Yes ◯ No

From who?_____

Medical History

History of Allergies? ◯ Yes ◯ No If yes, what? _____

History of Ear Infection? ◯ Yes ◯ No If yes, when did they start? _____

Level of severity? ◯ Severe ◯ Moderate ◯ Mild

Both ears? ◯ Yes ◯ No

Tubes in ears? ◯ Yes ◯ No If yes, when?_____

High fevers? (Above 104) ◯ Yes ◯ No

Current Medications: _____

_____

_____

Broken bones? ◯ Yes ◯ No Explain:_____

_____

_____

History of Physical Trauma? ◯ Yes ◯ No Explain:_____

_____

_____

History of Psychological Trauma? ◯ Yes ◯ No Explain:_____

_____

_____

Has a **vision test** been completed within the past 6 mo.: ◯Yes ◯No
Were glasses prescribed? ◯Yes ◯No
Where was test given?_____

Has a **hearing test** been completed within the past 6 mo.: ◯Yes ◯No
Where was test given?_____
Results? _____

Has an **intelligence evaluation** been completed within the past 6 mo.: ◯Yes ◯No
Who administered evaluation?_____
Results? _____

Has an **occupational therapy** evaluation been completed within the past 6 mo.: ◯Yes ◯No
Are occupational therapy services currently being provided? ◯Yes ◯No
If yes:
Where are services provided?_____
Occupational Therapist Name: _____

Has a **speech therapy** evaluation been completed within the past 6 mo.:
◯Yes ◯No
Is speech therapy services currently being provided? ◯Yes ◯No
If yes:
Where are services provided?_____
Speech Therapist Name: _____

Has your child been evaluated for **Attention Deficit Disorder** within the past 6 mo.: ◯Yes ◯No
Who administered evaluation?_____
Results? _____

Rate your child on the following items.

1 – Always 2- Frequently 3-Occasionally 4-Rarely 5-Never 6- Unknown

___ Hyperactive
___ Distracted
___ Short Attention Span
___ Frustrated
___ Impulsive
___ Fatigued
___ Awkward or Clumsy
___ Difficulty following verbal directions
___ Poor ability to organize work
___ Poor peer group relationships
___ Behavior
___ Emotional Problems
___ Variable School Performances

What has happen lately that has you interested in getting help?

_____

_____

_____

_____

How long has this been a concern?_____

List special programing at school:

☐ Reading program ☐ Speech Therapy ☐ Occupational Therapy ☐ IEP ☐ 504 ☐ Other:

_____

_____

Is there a family history of dyslexia or difficulties with reading?: ◯ Yes ◯ No

_____

_____

Additional comments:

_____

_____

_____

_____

_____

If you would be so kind as to provide feedback as to how you learned about DCT.

☐ Facebook ☐ Website (dyslexiatulsa.com) ☐

☐ Internet search: Key word searched: _____

☐ Tulsa Kids ☐ TV ☐ Friend ☐ Teacher ☐ Therapist ☐ Doctor

Please return, either email or fax 888-857-0023 along with a copy of clients Medicaid card. Once this has been received our office will begin the process to obtain the physician referral and Sooner Care authorization.