CHDR SCREENING FORM

Print Form

Completed by: **Date (MM-DD-YYYY):**

Child's First Name: **Child's Last Name:**

Age: **Gender:** **DOB (MM-DD-YYYY):**

Street No/Street: **Apt/Unit:**

State: **ZIP:** **Home Phone(###-###-####):**

Parent/Guardian Name: **Relationship:**

Cell (###-###-####): **E-mail:**

Grade: **School Program:**

Current Diagnoses

Date of diagnosis/Name of Doctor

ADHD/ADD: **Comment:**

Autism Spectrum: **Comment:**

Intellectual Disability **Comment:**

Mood Disorder: **Bipolar Disorder:** **Comment:**

Medications/Vitamins/Supplements

Name: **Dose/Reason Taken:**

Name: **Dose/Reason Taken:**

Name: **Dose/Reason Taken:**

Referral

Referral Source: **Problems/Concerns:**

Medical (Optional)

Medical Problems:

Recent Psychological Assessments (Optional)

Date/Age: **Assessments (if known):** **IQ/Results:**

Sensory/Communication/Motor:

Verbal/ Speaks in short phrases ☐ **Glasses/contacts:** ☐ **Hearing Problems:** ☐

Permission to contact for future research: ☐ **Primary Language:**

Insurance Info for Clinical Services /Or please fax a copy of your insurance card to 713-383-3719:

Insurance Co. ID#

Name of Insured: Group:

DOB of insured: Insurance Phone #:

Please return to:
Rosleen Mansour
1941 East Rd. Rm 2306
Houston, TX 77054

Rosleen.Mansour@uth.tmc.edu

Fax: 713-383-3719
Phone: 713-486-2591