



State of Alaska
Pediatric Neurodevelopmental Outreach and Autism Screening Clinic

Child's Name: _____ Date of Birth: _____ Age: ____yr ____mo ____ M ____ F ____

Parent(s) or Guardian(s) Name(s) _____ In foster care? Y / N

Daytime phone: _____ Cell _____ Email: _____

Mailing Address _____ City _____ Zip _____

Child's Primary Health Provider _____ Name of school/Preschool _____

Choose preferred clinic location: Homer Dillingham Bethel Fbks Barrow Kotzebue Nome Ketchikan Juneau Valdez Kodiak

Health Concerns	Y	N	Please explain concerns
Problems with growth			
Vision or hearing concerns			
Sleep problems			
Chronic illnesses			
Developmental Concerns	Y	N	Please explain concerns
Learning or cognitive delays			
Communication delays			
Motor delays			
Self-help delays (dressing, toileting)			
Being social with other children			
Likes to "pretend" play			
Behavioral Concerns	Y	N	Please explain concerns
Has frequent temper tantrums			
Aggressive towards self? Others?			
Extremely high or low activity level			
Poor attention control/distractible			
Plays with other children			
Happy most of the time			
Unusual fears			
Safety concerns/child fearless			
Routine bound			
Cries often			

What services is your child receiving (please check all boxes):

- Early Intervention/Infant Learning Public Health Nursing OT PT Speech Mental Health Services Dietary
 Head Start Spec Ed preschool Spec Ed classroom Other _____ Does child have IEP? Y / N

Please list others family members with a developmental concern:

Which insurance will be billed for this appointment: Medicaid/DKC Private IHS Tri-care Other: _____

What do you hope to gain from this assessment (Pls use reverse side to expand on concerns)?

Signed: _____ Relationship to child: _____ Date: _____