Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What would you like us to know about your child? What does he/she do well? Like? Dislike?
2. What would you like us to know about you/your family?
3. Do you have any concerns or worries for your child?
* Their growth/development
* Learning
* Sleeping
* Self-care
* Making and keeping friends
* Doing things for themselves
* Falling behind in school
* Behavior
* The Future
* Playing with friends
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Have there been any changes recently, such as:
* Brother or sister leaving home
* Move to a new town or home
* Sickness or death of a loved one
* New job
* Separation or Divorce
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Can we help you with any of the following needs?
* **Medical** (For example, help finding or understanding medical information; help finding health care for yourself or your family?
* **Social**  (For example, having someone to talk to when you need to; getting support at home; finding supports for the rest of your family?)
* **Educational** (For example, explaining your child’s needs to teachers; help reading or understanding medical information?)
* **Financial** (For example, understanding insurance or finding help paying for needs that insurance does not cover- such as medications, formula, or equipment?)
* **Legal** (For example, discussing laws and legal rights about your child’s health care or their school needs?)
* **General** (Please let us know what else you need help with. If we do not know, we will work with you to help find the answer.)

**Does your child have any unmet needs in the following categories?**

|  |  |
| --- | --- |
|  | **Please Describe** |
| **Well child check-up** |  |
| **Preventative dental care** |  |
| **Other dental care** |  |
| **Specialty care** |  |
| **Prescription medications** |  |
| **Physical therapy, occupational therapy or speech therapy** |  |
| **Eyeglasses or vision care** |  |
| **Hearing aids or hearing care** |  |
| **Mental health care or counseling** |  |
| **Substance use treatment or counseling** |  |
| **Home health care (like nursing, personal care assistance, etc)** |  |
| **Mobility aids or devices** |  |
| **Communication aids or devices** |  |
| **Durable medical equipment** |  |
| **Transportation** |  |
| **Other** |  |