Print Form

**CHDR SCREENING 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](mailto:Rosleen.Mansour@uth.tmc.edu)

Fax: 713-383-3719

Phone: 713-486-2591