DEVELOPMENTAL DISABILITIES INTAKE INTERVIEW

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES DIVISION
SFN 1859 (9-2020)

Clear Fields

Date of Referral	Referred By	
Date Completed	45 Day Deadline	Developmental Disabilities Program Manager (DDPM)
Interview Completed With		

Name of Client	Gender ☐ Male ☐ Female	Date of Birth

Address	City	State	ZIP Code

Email Address ☐ Okay to email

United States Citizen ☐ Yes ☐ No	Primary Language Spoken in Home	Race
Telephone Number ☐ Cell ☐ Home ☐ Work ☐ Okay to text		Best Time to Contact
Telephone Number ☐ Cell ☐ Home ☐ Work ☐ Okay to text		Best Time to Contact

Parents (biological/adoptive/foster)

Mother			Father		
Mother's Address			Father's Addresss		
City	State	ZIP Code	City	State	ZIP Code

Client is Living With
☐ Both Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Foster Parent(s) ☐ Alone
☐ Other (specify): _____

Name of Legal Custodian/Guardian ☐ Obtained a copy of guardianship papers

Address	City	State	ZIP Code

Other Children ☐ None

Name	Age

Name	Age

Indicate if any other occupants/animals live in the home
☐ Other People (specify): _____
☐ Cat ☐ Dog

Indicate additional information about the client's siblings or family members
☐ Adaptive Equipment ☐ Hearing Impairment ☐ Learning Difficulties ☐ Mental Health Concerns
☐ Seizures ☐ Speech Problem ☐ Other (specify): _____

PRIMARY CAREGIVER CONCERN(S)

What brought you to our program?

How do those concerns impact your daily routine, the client's routine, family activities, and interactions with others?

Is there anything else that impacts your day or the client's day?

What is the client's favorite part of the day? What are the client's strengths?

What is the client's least favorite part of the day? What are the client's needs?

Who are the family and friends involved in your family life and who provide support for you?

Recent Life Changes

☐ Birth of Sibling ☐ Death ☐ Divorce ☐ Move ☐ Other (specify): _____

HEALTH HISTORY

Name of Client's Physician

Name of Clinic	Name of Hospital

Mark if you have any of the following medical issues:

☐ Ear infections ☐ GI Problems ☐ Heart Condition ☐ Respiratory/RSV ☐ Seizures/Neuro

Diagnosis

Medications

Allergies

EDUCATIONAL HISTORY

Highest Grade Completed

Current School and/or Previous Schools Attended

WORK HISTORY

Describe current and previous work history:

SUPPORT/SERVICES

Other Support/Services Receiving

- ☐ Children's Special Health
- ☐ Human Service Zone
- ☐ Daycare _____
- ☐ Experienced Parent
- ☐ Family Voices
- ☐ Medicaid
- ☐ Medicare
- ☐ Outpatient (OT/PT/SLP) _____
- ☐ Others (church, friends, support groups) _____
- ☐ School _____
- ☐ SSI
- ☐ SSDI
- ☐ Social Security
- ☐ Vocational Rehabilitation
- ☐ WIC
- ☐ Workers with Disabilities

Mother/Caregiver's Employment	Father/Caregiver's Employment

Primary Health Insurance

Would you like any additional information on other supports that may be in the area?
☐ Yes ☐ No

Best Time of Day to Reach Caregiver/Guardian

BIRTH HISTORY (if client is under age three)

Was there anything unusual about the pregnancy?
☐ Yes ☐ No

If yes, describe:

Number of Weeks Pregnant	Birth Weight	Treatment Received While Pregnant
		☐ None ☐ Routine ☐ High Risk

Where was your child born?	Length of Time in the Hospital

Did your child pass the newborn hearing screen?
☐ Yes ☐ No

Describe additional testing your child received:

Did you have any vision concerns or examinations?
☐ Yes ☐ No

If yes, explain:

Mark any of the following concerns/special care in the first few weeks

☐ Apnea Monitor ☐ Breathing ☐ Feeding ☐ Jaundice ☐ Oxygen Use ☐ Seizures ☐ Swallowing ☐ Transfusions

☐ Other (specify): _____