CoxHealth

Patient Name: _____ Date of Birth: _____

NEEDS ASSESSMENT
PEDIATRIC

Date Completed: _____

Informant *(Form Completed by)*	**Relationship to Child**

Primary Language *(What language are you most comfortable speaking?)*			
○ English ○ Spanish	○ Other; specify which language		
Do you have any spiritual, cultural or ethnic beliefs that you wish for us to know?	○ yes	○ no	If yes, specify:
Do you have any physical or mental disabilities that require you to seek other's assistance in your child care?	○ yes	○ no	If yes, specify:
Who is the child's legal guardian(s)?	Specify:		
Will a legal guardian come with your child for each visit? If no, a Minor's Consent for Treatment will be required for persons whom you authorize to accompany your child to any visit. *Ask staff for Consent for Treatment of Minors authorization.*	○ yes	○ no	
List 3 phone numbers where we can contact you with questions or information.	1. 2. 3.		