Center for Developmental Pediatrics | **Patient Intake**

siskin children's institute

1.) IDENTIFYING INFORMATION

DATE COMPLETED _____

Child's Name: _____ Birth Date: _____ Sex: _____

Name & Relationship of person completing this form: _____

Do you have legal guardianship? Yes: ☒ No: ☐ If No, who does? Name/Phone _____

Primary language at home: English: ☐ Spanish: ☒ Other: ☐ _____

2.) CAREGIVER INFORMATION

Caregiver 1	**Caregiver 2** *(if applicable)*
Name:	Name:
Birth Date:	Birth Date:
Employer & Job:	Employer & Job:
Highest School Grade Completed:	Highest School Grade Completed:
Marital Status:	Marital Status:

3.) SOCIAL HISTORY

A. Please list all persons living in the child's home below:

Name	Age	Relationship to Child	Health

B. List any siblings living outside the home: _____

C. Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Other

D. If separated or divorced, is there shared custody? No: ☐ Yes: ☐

Arrangements: _____

E. Who else cares for the child? _____

F. If applicable:

1. Was the child adopted? No: ☐ Yes: ☐ If Yes, at what age? _____

Circumstances of adoption: _____

2. Has the child been in foster care? No: ☐ Yes: ☐ If Yes, complete the following.

Circumstances: _____

Total number of foster placements: _____

G. Has your child ever experienced the following:	Yes	No	Unsure
Serious illness, surgery, or hospitalization of a close family member?	☒	☐	☐
Death of a close family member or friend?	☐	☐	☐
Divorce/Separation of parents or caregivers?	☐	☐	☐
House fire, flood, storm, or other disasters?	☐	☐	☐
Alcohol or drug abuse by a family member?	☐	☐	☐
Seeing parents hitting/ hurting each other?	☐	☐	☐
Mental illness in a family member?	☐	☒	☐
Witnessing violence (robbery, shooting, etc.)?	☐	☐	☐
Physical abuse?	☐	☐	☐
Sexual abuse?	☐	☐	☐
Change in primary caregiver?	☐	☐	☐

4.) PARENTAL CONCERNS

Describe what concerns you have about your child's development, learning, and/ or behavior? (Please indicate the age these concerns were first noticed.) _____

_____

Has your child had previous evaluations for these concerns? No: ☐ Yes: ☐ If so, where: _____

What do you hope to accomplish during this visit? _____

_____

Describe your child's …

Strengths: _____

Challenges: _____

5.) DEVELOPMENTAL CONCERNS

A.) Speech & Language

1. Do you have any concerns about your child's communication skills? ☐ No ☐ Yes, explain:

2. Does your child mostly communicate by: ☐Crying ☐Grunting ☐Nonspecific gesturing ☐Pointing index finger ☐ Using single words ☐Using complete sentences ☐Using phrases ☐ Using your hand to obtain desired object
3. Did your child begin to use words to communicate and then stopped? No: ☐ Yes: ☐ If Yes, at what age? _____
4. If your child uses phrases and sentences to communicate, does he/she participate in back-in-forth conversations with others? No: ☐ Yes: ☐

B.) Social Development

1. Describe your child's interactions with peers. _____
2. Does your child bring you toys or other objects? No: ☐ Yes: ☐
3. Does your child point to objects to show you that are interesting to him/her? No: ☐ Yes: ☐
4. Does your child respond to his/her name being called? No: ☐ Yes: ☐
5. Does your child wave goodbye or engage in any social interaction games (like Peek-a-boo, pat-a-cake, itsy bitsy spider, ect.)? No: ☐ Yes: ☐

C.) Play Skills

Favorite toys, objects, activities: _____

Describe your child's play: _____

D.) Motor Skills

1. Do you have any current concerns about your child's motor skills?
   Gross Motor: No: ☐ Yes: ☐ Fine Motor: No: ☐ Yes: ☐
2. Does your child have problems with balance and/ or coordination? No: ☐ Yes: ☐

E.) Sensory Skills

1. Any concerns in the areas of: (avoids and/ or seeks out behaviors)
   ☐ Sense of touch ☐ Hearing ☐ Oral ☐ Smell ☐ Vision ☐ Movement ☐ Pain Threshold
   Explain: _____

6.) BEHAVIOR

A.) How frequently does your child have temper tantrums, and how long do they last?

_____

B.) What typically trigger a tantrum and when do they usually occur?

_____

C.) What helps your child calm down?

_____

D.) Does your child engage in any unusual repetitive behaviors? Any specific routines or interest?

_____

E.) Other:

_____

7.) FEEDING/ NUTRITION

Do you have concerns about your child's eating or mealtime behavior? No: ☐ Yes: ☐

*If you answered **Yes**, complete the following. If you answered **No**, skip to the next section (**SLEEP**)*

☐ Has difficulty chewing and/or swallowing certain foods ☐ Eats a limited variety of foods compared to peers ☐ Gets the majority of calories from drinking ☐ Is currently being treated by a gastroenterologist for feeding related concerns ☐ Frequently experiences respiratory illnesses and/or has a history of pneumonia	☐ Has food allergies/ intolerance ☐ Vomits multiple times per week ☐ Complains frequently of stomach pains ☐ Coughs and/or chokes while eating and/or drinking ☐ Is dependent on tube feeds ☐ Takes a long time to eat ☐ Tantrums or cries during meals or refuses to eat the family meal ☐ Refuses to sit at the table for meals

8.) SLEEP

Does your child currently have sleep problems? No: ☐ Yes: ☐ If Yes, check all that apply:

☐Bedtime Refusal ☐Mouth Breathing ☐Teeth Grinding ☐Sleep Talking
☐Snoring ☐Restless ☐Sleep Walking ☐Other
☐Delayed Sleep Onset ☐Nightmares or Terrors ☐Will Not Sleep Alone

Did your child have sleep problems as an infant?
No: ☐ Yes: ☐ If Yes, explain:

_____

Does your child still take day-time naps?
No: ☐ Yes: ☐ If Yes, when and how long?

What time is your child …
In bed: _____ Asleep: _____ AM wake up: _____

Does your child have a TV in his/her bedroom?
No: ☐ Yes: ☐

Does your child utilize electronic media within 1 hour of bedtime?
No: ☐ Yes: ☐

9.) SCHOOL HISTORY

A. Current school and preschool/daycare: _____ Grade: _____

B. Are you satisfied with your child's performance at school? No: ☐ Yes: ☐ If No, why? _____

C. Does your child have an IEP (Individualized Education Plan) or a 504 plan? No: ☐ Yes: ☐

D. Has your child had or is your child scheduled to have developmental and/ or psychoeducational testing? No: ☐ Yes: ☐

E. Is your child receiving additional services through the school? No: ☐ Yes: ☐ If Yes, select from the following:

☐Self- Contained Special Education ☐Occupational Therapy (OT)
☐Resource Room ☐Physical Therapy (PT)
☐Classroom Modifications ☐Tutoring
☐Speech/Language Therapy (ST) ☐Other

10.) THERAPY

Has your child ever been recommended for or received therapy outside of school (e.g. Early Intervention)? No: ☐ Yes: ☐
If Yes, select from the following:

Therapy	Current	Location	Dates
Speech and Language Therapy (ST)	☐ No ☐Yes		
Occupational Therapy (OT)	☐ No ☐Yes		

Physical Therapy (PT)	☒ No ☐Yes		
Behavior Therapy/ Counseling	☐ No ☐Yes		
Other	☐ No ☐Yes		

11.) PREGNANCY HISTORY

Did the birth mother…	No:	Yes:	What month(s) of pregnancy?	Complications and or/ medications?
Receive prenatal care?	☐	☐		
Have illness or medical problems?	☐	☐		
Have any known exposures to x-rays, toxins, or chemicals?	☐	☐		
Take prescription medications?	☐	☐		
Smoke? *(indicate how much)*	☐	☐		
Drink alcoholic beverages? *(indicate how much)*	☐	☐		
Use illicit drugs/ substances *(type and amount, if known)*	☐	☐		

12.) BIRTH INFORMATION

Length of pregnancy?	Birth weight?
Length of labor?	Did the baby need medical assistance in starting to breathe? No: ☐ Yes: ☐
Age of mother at delivery?	Was the baby admitted to the NICU? No: ☐ Yes: ☐ If yes, for how long?
Labor/Delivery complications?	How long did the baby stay in the hospital after birth?
Was labor induced & why?	Did the baby have health problems in the first 12 months after birth?
Birth was … ☐Vaginal ☐C-Section ☐Breech ☐ Twins or more	

13.) MEDICAL HISTORY

List past medical problems, including other specialty providers caring for your child:

A.) Medication

List all medicines, vitamins, or supplements your child currently takes:

Name	Amount	Reason

Indicate previous medications for behavior or sleep:

Name	Dosage	Dates Taken	Response

Does your child have allergies to any medications? No: ☐ Yes: ☐ If Yes, to what? _____

B.) Hospitalizations/ Surgeries

Has your child ever been hospitalized (including psychiatric hospitalization), had surgery, and/or had a major injury? No: ☐ Yes: ☐

Reason	Date	Hospital

C.) Immunizations

Child's immunizations are … ☐ Up to date ☐ Incomplete ☐ Unknown status

D.) Date of last Vision Test and results? **Date of last Hearing Test and results?**

E.) Previous Medical Testing?

Test:	Result:	Date:
☐Genetic Testing		
☐CT Scans		
☐MRI Scans		
☐Sleep Study		
☐Allergy Testing		
☐Swallowing Studies		
☐Other:		

F.) Review of Systems: Has your child ever had any of the following?

System		Age	Details	System		Age	Details
Head	☐ Head Injuries			**Lungs**	☐ Repeated exposure to tobacco smoke		
	☐ Hydrocephalus				☐ Asthma		
Eyes	☐ Vision Problems				☐ Pneumonia		
	☐ Glasses			**Endo**	☐ Height/ Growth Problem		
Ears	☐ Hearing Problems				☐ Diabetes		
	☐ Recurrent Ear Infections			**GI**	☐ Soiling Day/ Night		
	☐ Hearing Aids				☐ Stomachache		
Nose	☐ Nosebleeds				☐ Weight Problem		
	☐ Recurrent Sinus Infections			**MS**	☐ Clumsiness		
Teeth	☐ Teeth Grinding				☐ Weakness		
	☐ Cavities				☐ Broken Bones		
Throat	☐ Recurrent Strep			**Neuro**	☐ Meningitis		
Allergy	☐ Seasonal				☐ Headache		
	☐ Food				☐ Dizziness		

Skin	☐ Dermatitis/ Eczema				☐ Seizures		
	☐ Birthmarks				☐ Tics		
Blood/ Lymp	☐ Lead Poisoning			**Psych**	☐ Depression		
	☐ Anemia				☐ Anxiety		
	☐ Bleeding				☐ Aggression		
Heart	☐ Heart Defects				☐ Disruptive Behavior		
	☐ Heart Murmur				☐ Suicide/Homicidal Ideation		
	☐ Chest Pain				☐Hallucinations		

14.) DEVELOPMENTAL MILESTONES

At what age did your child meet these milestones? Indicate age in months. (*If milestone has not been met, mark N/A.)*

Motor	Self-help	Language
Rolled Over:	Hold bottle:	Babble:
Sit without support:	Stop using bottle:	Say Mama/Dada:
Crawl:	Fed Self:	Say another word:
Stood without support:	Use spoon:	Understand "no":
Walk Alone:	Use fork:	Point:
Run:	Drink from open cup:	Wave:
Navigate stairs:	Undress:	Follow a command:
Pedal tricycle:	Toilet trained:	Points to body parts:
Ride a bike:	Dry at night:	Use 2-word phrases:
Use a pincer grasp:	Dress self:	Use 3-word phrases:
Prefer one hand:	Tied shoelaces:	
Scribbled:		
Climbed stairs with rail:		

15.) FAMILY HISTORY

No known family health problems? ☒ Unknown, child was adopted: ☐ Unknown for another reason: ☐ / Explain below

Please indicate if any of the child's relatives have had any of the following (ex: parent, sibling, grandparent, aunts/uncles, cousins, etc.).

CONDITION	WHICH FAMILY MEMBER
☐ ADHD/ Attention Problems	
☐ Autism Spectrum Disorder	
☐ Behavior problems	
☐ Birth defects	
☐ Congenital Heart Disease	
☐ Cerebral Palsy	
☐ Convulsions/ Seizures	
☐ Developmental Delay	
☐ Early or Sudden Death, if so cause:	
☐ Genetic Disorder	
☐ Hearing problems/ Vision problems	
☐ Hypertrophic Cardiomyopathy	
☐ Intellectual Disability	
☐ Language/ Speech problems	

☐ Learning Problems	☐ Reading ☐ Math ☐ Writing ☐ Other
☐ Long QT Syndrome	
☐ Tics/ Tourette Syndrome	
☐Thyroid Disorder	
☐ Sleep Disorder	
☐Wolff-Parkinson-White syndrome	
☐Mental Illness:	
☐Anxiety	
☐Bipolar Disorder	
☐Depression	
☐Obsessive Compulsive Disorder (OCD)	
☐Schizophrenia	

Please note any other relatives with conditions not listed above in the space below:

What are your primary sources of support (Example: family, friends, church, work, support group)?

Please use the area below for any other information you feel will be helpful to use in evaluating your child.

By providing my signature below, I affirm that I have truthfully answered the questions within this document to the best of my ability. I understand that I have an affirmative responsability to disclose any changes to this information to the provider as they may occur.

Signature _____ Date _____