Center for Developmental Pediatrics | Patient Intake

siskin children's institute

1. IDENTIFYING INFORMATION

DATE COMPLETED _____

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

Name of person completing this form: _____

You are: ☐ Biological Parent ☐ Adoptive Parent ☐ Foster Parent Other: _____

Do you have legal guardianship? Yes: ☐ No: ☐ If No, who does? _____

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

2. CAREGIVER INFORMATION

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

3. 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 are your goals for this visit? _____

_____

Describe your child's

Strengths: _____

Challenges: _____

4. THERAPY SERVICES

Has your child ever been recommended for or received therapy outside of school? 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		
Early Intervention (TEIS, BCW)	☐ No ☐Yes		
Other (e.g. ABA)	☐ No ☐Yes		

5. DEVELOPMENTAL MILESTONES

To the best of your abilities, please write at what age did your child meet these milestones? Indicate age in months. (*If milestone has not been met, mark N/A.)*

Motor	Language
Rolled Over:	Babble:
Sit without support:	Say Mama/Dada:
Crawl:	Say another word:
Stood without support:	Point with index finger:
Walk Alone:	Wave:
Run:	Follow a command:
	Points to body parts:
	Use 2-word phrases:
	Use 3-word phrases:

6. CURRENT DEVELOPMENT

A.) Motor Skills

1. Do you have any concerns about your child's **gross** motor skills? (i.e. running, climbing, jumping) ? No: ☐ Yes: ☐
2. Do you have any concerns about your child's **fine** motor skills? (i.e. using their hands, holding utensils, etc.) No: ☐ Yes: ☐
3. Any history of regression in motor skills? (Lost skills, stopped doing things he/she was doing?) No: ☐ Yes: ☐

SKILL	NO	YES
Does your child have problems with balance/coordination?	☐	☐
Can your child use a spoon to eat?	☐	☐
Can your child use a fork to eat?	☐	☐
Can your child drink from an open cup?	☐	☐
Can your child scribble with a pen/crayon?	☐	☐
Is your child toilet/potty trained? At what age? _____	☐	☐
Can your child undress self?	☐	☐
Can your child dress self?	☐	☐

B.) Speech & Language

Expressive Language

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

2. Currently, is your child? Non-verbal ☐ Babbling ☐ **Using**: Single words ☐ Phrases ☐ Full sentences ☐
3. How many words is your child saying spontaneously? (not repeating after others) _____
4. Any history of language regression? (was saying words and then stopped) No: ☐ Yes: ☐
5. How does your child ask for help? (please check all that apply)

BEHAVIOR	PLEASE CHECK
Sign Language	☐
Crying	☐
Grunting	☐
Non-specific gesturing	☐
Pointing with index finger	☐
Using your hand to obtain desired objects	☐
Giving objects to others	☐
Using words/language	☐
Does not ask for help	☐

Receptive Language

1. Can your child follow directions? No ☐ Only a few familiar/routine ☐ One step ☐ Multiple Steps ☐

Repetitive Language

6. Does your child use language in a repetitive way? _____

7. Does your child repeat words just spoken by others? (i.e.: repeating a question or the last word of the question instead of answering it) No: ☐ Yes: ☐ If yes, how often? _____

8. Does your child repeat phrases/words from movies or TV shows? (not songs) If yes, how often and in what context (please explain)

No: ☐ Yes: ☐ _____

C.) Social Development

When answering these questions, please note that **YES** means that your child does these behaviors **MOST** of the time, and not only occasionally/rarely.

Does your child exhibit any of the following behaviors?

SKILL	NO	YES
Looks at you when you call his/her name	☐	☐
Typically looks at others when he/she is talking/saying words	☐	☐
Makes eye contact with others when he/she is talked to?	☐	☐
Smiles back in response to other's smile?	☐	☐
Shares enjoyment with others? (Looks for others to interact?)	☐	☐
Shows objects to others and make eye contact?	☐	☐
Points at objects with index finger to draw your attention (not to request)	☐	☐
Points at objects with index finger to request?	☐	☐
Gives things to others to share? (not to request)	☐	☐
Gives things to others to request?	☐	☐
Shows interest in other children?	☐	☐
Appears withdrawn/in their own world?	☐	☐
Plays interactively with others? (such as back-and-forth play)	☐	☐
At home, does your child prefer playing alone?	☐	☐
Looks for others to play with him/her (not just for help)	☐	☐
Uses gestures? (waves bye-bye, nods, shakes head, etc.)	☐	☐
Uses others' people's hands and move them towards objects?	☐	☐

D.) Play Skills

1. Describe your child's play, favorite toys, etc.: _____

2. Does your child engage in pretend play? (Feeding pretend food to baby dolls, stuffed animals, play pretend kitchen, play doctor, etc.) If so, how often (rarely, occasionally, often) _____

3. Does your child play with the toys the way they are intended to be used? (i.e.: he/she will roll cars, make train noises, use a bottle to feed a baby doll, etc.) _____

4. Are there certain objects that your child prefers to play with instead of toys? (i.e. strings, clothing hangers, cords, straws, etc.) _____

E.) Repetitive Behaviors

Does your child exhibit any of the following behaviors?

BEHAVIOR	NO	YES
Lines up objects	☐	☐
Spins objects	☐	☐
Flaps hands when upset or excited	☐	☐
Walks on tiptoes	☐	☐
Gets upset with changes in routines	☐	☐
Has difficulty with transitions	☐	☐
Is very rigid with how things need to be done/routines	☐	☐
Gets fixated on specific topics, toys, objects, TV shows	☐	☐

F.) Sensory

Does your child exhibit any of the following behaviors?

BEHAVIOR	NO	YES
Brings toys close to his/her eyes? Or inspects things from different angles	☐	☐
Seeks to touch or rub certain textures	☐	☐
Dislikes certain texture with food or touch	☐	☐
Has issues with loud noises?	☐	☐
Has problems with clothing, socks	☐	☐
Has a fascination with observing movements of things? (i.e. fans, wheels)	☐	☐
Smells objects/food	☐	☐

Do you think your child has autism/is autistic? No: ☐ Yes: ☐ I don't know ☐

7. BEHAVIOR

1. Do you have any concerns about your child's behaviors? No: ☐ Yes: ☐
2. Does your child exhibit any of these behaviors? (please check all that apply)
   - Self-injury ☐
   - Aggression towards others ☐
   - Destruction of property ☐
   - Elopement ☐
   - Severe disruptive behavior ☐
3. Are you concerned for your child's or others' safety? No: ☐ Yes: ☐
4. Does your child's behavior significantly interferes with home or community activities? No: ☐ Yes: ☐
5. If temper tantrums are occurring, where are they happening? (i.e. school, home, daycare, etc.)

8. FEEDING/ NUTRITION

1. Does your child eat a limited variety of foods compared to peers? No: ☐ Yes: ☐
2. Is your child very rigid with what he/she eats and only eats certain foods? No: ☐ Yes: ☐
3. Does your child cough and/or choke while eating and/or drinking No: ☐ Yes: ☐

9. SLEEP

Does your child currently have sleep problems? No: ☐ Yes: ☐ Explain:
Does your child: ☐Snore ☐Take a long time to fall asleep ☐ Has pauses while breathing during sleep

1. What time is your child: In bed: _____ Asleep: _____ AM wake up: _____
2. Does your child wake up in the middle of the night? No: ☐ Yes: ☐
   - How many times? _____
   - How long does he/she stay awake? _____
3. Does your child take any medication for sleep? No: ☐ Yes: ☐ If yes, which one and dose: _____

10. SCHOOL INFORMATION

1. Current school /preschool/daycare: _____ Grade: _____
2. Are you satisfied with your child's performance at school? No: ☐ Yes: ☐ If No, why? _____
3. Does your child have an IEP (Individualized Education Plan)? No: ☐ Yes: ☐ or a 504 plan? No: ☐ Yes: ☐
4. Is your child receiving additional services through the school? No: ☐ Yes: ☐ If Yes, select from the following:

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

11. MEDICAL HISTORY

A.) 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?	☐	☐		
Take prescription medications?	☐	☐		
Smoke? *(indicate how much)*	☐	☐		
Drink alcoholic beverages? *(indicate how much)*	☐	☐		
Use illicit drugs/ substances *(type and amount, if known)*	☐	☐		

B.) Birth History:

Length of pregnancy?	Birth weight?
Was labor induced & why?	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?
Birth was ☐Vaginal ☐C-Section ☐Breech ☐ Twins or more	

C.) Past Medical History:

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

1. Medications

Is your child allergic to any medications? No: ☐ Yes: ☐ If Yes, to what? _____

List all medicines, vitamins, or supplements your child currently takes (including for behavior or sleep)

Name	Dosage	Dates Taken	Reason/Response

2. Hospitalizations/ Surgeries

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

Reason	Date	Hospital

3. Immunizations are: ☐ Up to date ☐ Incomplete ☐ Unknown status

4. Date of last Vision Test and results? **Date of last Hearing Test and results?**

5. Previous Medical Testing

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

D.) Social History

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

Name:	Age:	Relationship to Child:	Health:

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

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

Arrangements: _____

D. Who else cares for the child? _____

E. If applicable, was the child adopted? No: ☐ Yes: ☐ If Yes, at what age? _____

Circumstances of adoption: _____

If applicable, has the child been in foster care? No: ☐ Yes: ☐

Circumstances: _____

Total number of foster placements: _____

F. **Has your child ever experienced the following:**

	Yes	No	Unsure
Alcohol or drug abuse by a family member?	☐	☐	☐
Seeing parents hitting/ hurting each other?	☐	☐	☐
Witnessing violence (robbery, shooting, etc.)?	☐	☐	☐
Physical abuse?	☐	☐	☐
Sexual abuse?	☐	☐	☐

E.) Family History

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

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

CONDITION	FAMILY MEMBER	CONDITION	FAMILY MEMBER
☐ ADHD/ Attention Problems		☐ Tics/ Tourette Syndrome	
☐ Autism Spectrum Disorder		☐Thyroid Disorder	
☐ Behavior problems		☐ Sleep Disorder	
☐ Birth defects		☐Wolff-Parkinson-White syndrome	
☐ Congenital Heart Disease		☐Mental Illness:	
☐ Cerebral Palsy		☐Anxiety	
☐ Convulsions/ Seizures		☐Bipolar Disorder	
☐ Developmental Delay		☐Depression	
☐ Early or Sudden Death, if so cause:		☐Obsessive Compulsive Disorder (OCD)	
☐ Genetic Disorder		☐Schizophrenia	
☐ Hearing problems/ Vision problems		☐ Long QT Syndrome	
☐ Hypertrophic Cardiomyopathy		☐ Language/ Speech problems	
☐ Intellectual Disability		☐ Learning Problems	

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

12. 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		
					☐ Suicide/Homicidal Ideation		
					☐Hallucinations		

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

REVIEW & SIGN:

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 responsibility to disclose any changes to this information to the provider as they may occur.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____ _____