Great Changes Resource Center, PLLC
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Pediatric Intake Form

The information you provide will help staff determine the care you need as well as any further assessments. A patient's individual background and cultural and family surroundings are important factors in her or his response to illness and treatment.

Date: ______________________

FAMILY AND MEDICAL HISTORY FORM

Patient's Name: ______________________ Date of Birth: ______________
Referring Physician's Name: ______________________
Home Address: ______________________ City: ______________
Home Phone: ______________ Business Phone: ______________ Other (pager, cell) ______________
E-mail Address: ______________________

Pregnancy and Birth History:

Please list all pregnancies in order (including this child, miscarriages, terminations or deceased):

PREGNANCY #	BIRTH WEIGHT	ANY DELIVERY, HEALTH OR DEVELOPMENTAL PROBLEMS	FATHER
1			
2			
3			
4			
5			
6			

Pregnancy complications with this child: ______________________

Gestational age at time of delivery (or # of weeks early or late): ______________
What type of delivery (please circle one)? Vaginal Cesarean Section = elective or emergency
Birth Weight: ______________ Length: ______________
What were your child's APGAR scores? 1 minute ______________ 5 minutes ______________
Was your child in the NICU? Yes NO If so, how long? ______________
Please describe any complications that occurred during NICU hospitalization: ______________

Medical History:

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	

ITEM	NO	YES	DESCRIPTION	EXPLANATION
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint / bone problems (include x-rays, bone scans)	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions (include any EEG's)	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			MRI / CAT scan / Injections	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

Has your child had any difficulties with feeding (i.e., sucking, swallowing, drooling, chewing, choking)? If yes, describe: ____

____

Hospitalizations/Surgeries including approximate dates: ____

____

____

List the current medications your child is taking, if any (please include any over the counter medications or medications given as needed): ____

____

____

Is your child ALLERGIC to any drugs? Yes ____ No ____ If yes, what drugs? ____________________

Please list reactions to allergy along with severity: ______________________________

Is your child ALLERGIC to any foods? Yes ___ No ___ If yes, what? ______________________________

Please list reactions to allergy along with severity: ______________________________

Does your child use any special equipment for daily activities, such as:

Glasses ____ Hearing Aide _____ Splints _____ Walker _____ Crutches _____ Wheelchair _____
Other: ______________________________

Can your child see and hear well? ______________ Has vision/hearing been formally evaluated? ________

Previous evaluations/services: *Who* *Where* *When*

Occupational Therapist ______________________________
Physical Therapist ______________________________
Speech Therapist ______________________________
Psychologist ______________________________
Other ______________________________

HAS YOUR CHILD HAD ANY THERAPY THIS CALENDAR YEAR HERE OR AT ANOTHER FACILITY? YES ____ NO ____

Nutritional

Please answer the following questions regarding your child's nutritional status.	Yes	No	N/A
My child has had no recent weight gain.			
My child has chewing or swallowing problems that make it difficult to eat. If yes, please explain:			
My child has had significant unexplained weight loss or gain in the past three months.			
My child has an open non-healing wound.			

Does your child have intolerances or dislikes of major food groups such as grains, fruits, starches, milk, protein, etc? If so, please describe: ______________________________

Developmental history:

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Smiled							
Said first words / names single objects							
Combine words (i.e., me go, dad shoe)							

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Use simple questions (i.e., where's mom?)							
Followed simple 1 step directions							
Said 2-3 phrases							
Knew colors							
Counted to 5							
Knew alphabet							
Held head up							
Rolled over							
Sat unsupported							
Crawled on hands and knees							
Stood alone							
Walked by self							
Threw objects actively							
Ran by self							
Pedal a tricycle							
Pedal a bicycle independently							
Caught a thrown object							
Feeds self: (finger feed / eats with spoon / fork)							
Drink from: (bottle / spouted or special cup / regular cup)							
Brush teeth: (tolerates from parent / independent)							
Dressed self							
Manipulates buttons, zippers, shoelaces							
Bladder trained - days							
Bladder trained - nights							
Bowel trained							
Sleeps through the night							
Shows a hand preference (which?)							
Reached for an object actively							
Transferred object between hands							
Clap hands							
Pick up Cheerios or other similar object							
Cut paper with scissors							
Scribble with a crayon							

Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Masturbation	
11			Fire play or cruelty to animals	
12			Major mood swings	
13			Under or over reactive to sounds	
14			Under or over reactive to clothing	
15			Under or over reactive to taste	
16			Under or over reactive to smell	
17			Any unusual fears?	

General Information:

Father's Name:____ Date of birth:______________________

Occupation:___________________________________ Highest Educational Level:_______________________

Religion:_____________________ Relationship to child: (please circle): Biological Adoptive Step Foster Other

Mother's Name:____ Date of birth:______________________

Occupation:___________________________________ Highest Educational Level:_______________________

Religion:_____________________ Relationship to child: (please circle): Biological Adoptive Step Foster Other

Brother's and Sisters (please include ages):____

If both primary caregivers work, who cares for the child? ____

________________________________When is child with this caregiver?_________________________________

FAMILY STRESSORS (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	EVENT	EXPLANATION
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event	

Do you have financial concerns related to paying your bill? ______ Yes ______No

Social

Is your child in school? Yes ______ No ______ If yes, where? ________________________________

What grade? ______ Is he/she in any special classes or have special needs?________________________

Has your child missed any school because of this condition? ______ If yes, how much? ________________

How much, if any, have the current symptoms interfered with your child's social activities? ______________

____

Describe your current support system at home for your child's treatment: ________________________

____

Reason for visit:

Briefly state the reason your child is being evaluated (include reasons for each evaluation if receiving more than one):

____

____

____

When did you first notice the problem(s)? ______________________By whom? ____________________

How does your child usually communicate (gestures, single words, short phrases, sentences)?

____

How does your child feel about their current condition? ______________________________________

Child / Family concerns and goals

Please describe the major concerns and / or goals you have in seeking help for your child. List your concerns in order of their importance to you.

1. ____
2. ____
3. ____
4. ____
5. ____

Other

Who is your child's Pediatrician or Family Doctor? ____

Address: ____

Phone #:______________________________

Parent Signature: ________________________________ ***Date:*** ____________________