NEW PATIENT INTAKE

Date: _____

BACKGROUND:

Name: _____ Grade:_____

Date of birth:_____ Gender: ☐ M ☐ F ☐ Other_____

Address: _____

City:_____ State:_____ Zip:_____

Email address:_____ Phone:_____ Cell Phone:_____

Person completing form:_____ Relationship to child: _____

Child's Doctor: _____

Address: _____

City:_____ State:_____ Zip:_____ Phone:_____

Who referred child for evaluation/consultation:_____

What are your concerns or questions about your child?_____

_____

_____

When did you first become concerned? _____

What caused you to become concerned? _____

_____

What would you like to accomplish during this evaluation or therapy?_____

_____

MEDICAL HISTORY:

Is child adopted? ☐ Yes ☐ No In foster care? ☐ Yes ☐ No

How old was mother when she became pregnant?_____

How far along was mother when pregnancy was recognized?_____

How long was the pregnancy? ☐ Full Term ☐ Other *(specify):* _____

Did the mother experience any health problems during pregnancy? *(check all that apply)*

☐ Inadequate weight gain ☐ Excessive weight gain ☐ High blood pressure

☐ Gestational diabetes ☐ Protein in the urine ☐ Other: _____

Did mother smoke during pregnancy? ☐ No ☐ Yes *(how much):*_____

Did mother drink alcohol during pregnancy? ☐ No ☐ Yes *(how much per week)*:_____

Birth hospital: _____ How long did labor last? _____

How was baby born? ☐ Vaginal delivery ☐ Cesarean delivery

Birth weight:_____ How long did baby stay in the hospital?_____

Any problems during delivery? _____

_____

Did baby have any medical problems after birth? _____

_____

Are you concerned that you may have done something or that somthing may have occurred during the pregnancy or delivery to cause your child's difficulties: _____

_____

Is your child growing well? ☐ Yes ☐ No If No, explain: _____

Immunizations up-to-date? ☐ Yes ☐ No If No, explain: _____

Allergies? ☐ Yes ☐ No If Yes, please specify: _____

Frequent ear infections? ☐ Yes ☐ No If Yes, please specify: _____

Seizures? ☐ Yes ☐ No If Yes, please specify:_____

Any fractured/broken bones? ☐ Yes ☐ No If Yes, please specify: _____

Please list any hospital admissions for your child:

Date:_____ Hospital:_____ Reason: _____

Date:_____ Hospital:_____ Reason: _____

Date:_____ Hospital:_____ Reason: _____

Please list any medications your child takes on a regular basis (including for any mental health concerns):

_____

_____

Has your child's hearing and vision been checked? ☐ Yes ☐ No

If Yes, where and what were the results:_____

_____

DEVELOPMENTAL HISTORY:

Approximate age when child met these milestones:

Walking: _____

First words: _____

Sentences: _____

Toilet training *(day):* _____

Toilet training *(night)*:_____

Any early intervention? ☐ Speech ☐ OT ☐ PT If Yes, please specify:_____

_____

_____

How clear is child's speech, that is, how much of child's speech can a stranger understand?

☐ All or almost all ☐ About half ☐ Less than half

How old does child act? _____

Has child lost any abilities (explain/specify)? _____

_____

_____

BEHAVIORAL HISTORY:

How would you describe your child's personality?

As an infant or toddler: _____

As a child: _____

How does your child get along with others? _____

_____

What does your child like to do for play? _____

_____

Does your child have difficulty with any of the following (check all that apply):

☐ Sleeping ☐ Eating ☐ Tantrums ☐ Head banging ☐ Hitting ☐ Biting

☐ Lying ☐ Stealing ☐ Mouthing or eating non-food items ☐ Impulsive ☐ Hyperactive

☐ Short Attention Span ☐ Forgetful ☐ Aggressive ☐ Destructive ☐ Toileting

☐ Other: _____

How do you handle these behaviors? _____

_____

_____

EDUCATIONAL HISTORY:

Please list all schools or early intervention programs your child has attended:

Year	Age	Schools / Early Intervention Programs	Grade / Type of Service

Does your child have difficulties in school or receive any tutoring or extra support? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

PREVIOUS EVALUATIONS:

Has your child had any prior evaluations, therapy or treatments? ☐ Yes ☐ No If Yes, please list below:

Date	Type of Professional	Result/Diagnosis (if given)	Medications

Does your child have any special education services provided (IEP or 504 plan)? ☐ Yes ☐ No

If Yes, please provide below: _____

_____

FAMILY HISTORY:

	Name	Age	Highest Grade level	Occupation
Father				
Mother				

	Name	Age	Gender	Any Developmental concerns?
Sibling				
Sibling				
Sibling				

Is there anybody in the family with any of the following (check all that apply and explain below):

☐ Developmental delay ☐ Mental retardation ☐ Learning disability ☐ Speech/language delay

☐ ADHD ☐ Cerebral palsy ☐ Autism/PDD ☐ Seizure disorder ☐ Anxiety ☐ OCD

☐ Depression ☐ Bipolar disorder ☐ Eating disorder ☐ Schizophrenia

☐ Other: _____

If any are checked, please explain:_____

_____

_____

Who lives at home with the child? _____

The following statements MUST be signed by ALL patients, age 14 and over.
If patient is under 14, parent must sign:

My signature below indicates that I have read and understood the office policies of Childhood Solutions, PC.

I also understand that failure to pay for any services rendered can result in legal action.

Signature: _____

Relationship to patient: _____ Date: _____

I give my consent for Childhood Solutions, PC to evaluate and/or treat my child who is under 14 years of age.

Signature: _____

Relationship to patient: _____ Date: _____

Please tell us anything else you think may be important for us to know:_____

_____

_____

_____

_____

_____

_____

_____

_____