Developmental & Behavioral Pediatrics
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INTAKE PACKET

DEMOGRAPHICS

Email: _____ **Today's Date:** _____

Child's Name: _____ **Preferred Name:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Birth Sex:** ☐ F ☐ M **Birthplace:** _____

Person completing form_____ **Relationship to child:** _____

Mailing address: _____

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

Parent 1: _____ **Parent 2:** _____

Legal Guardian: ☐ Yes ☐ No **Legal Guardian:** ☐ Yes ☐ No

CONCERNS

CURRENT CONCERNS:

- ☐ Developmental Delay
- ☐ Slow or late to talk
- ☐ Way your child moves and/or walks
- ☐ Poor attention/hyperactivity (ADHD)
- ☐ School Performance
- ☐ Developmental Delay
- ☐ Slow or late to talk
- ☐ Behavioral problem
- ☐ Sensory issue
- ☐ Sleep
- ☐ Social problems

Other: _____

_____

CHECK PREVIOUS OR CURRENT DIAGNOSES:

- ☐ None
- ☐ ADHD
- ☐ Autism/ASD/Aspergers/PDD NOS
- ☐ Cerebral Palsy
- ☐ Conduct/Oppositional defiant disorder
- ☐ Epilepsy or seizure disorder
- ☐ Genetic Disorder (list here):
- ☐ Intellectual disability
- ☐ Learning disorder
- ☐ Language disorder
- ☐ Psychiatric (list here):
- ☐ Tic disorder
- ☐ Developmental delay
- ☐ Hearing loss/impairment
- ☐ Visual loss/blindness

Other: _____

_____

Anything not listed or additional concerns:

_____

_____

_____

_____

PAST MEDICAL HISTORY

PREGNANCY HISTORY:

*****THIS INFORMATION RELATES TO THE BIOLOGICAL PARENT*****

Birth patent's age when child was born: _____ What number of pregnancy for birth parent: _____

Complications/illnesses during pregnancy:

_____

_____

Substance use during pregnancy: ☐ Alcohol ☐ Tobacco ☐ Drugs ☐ Medications ☐ Other: _____

Type of delivery: ☐ Natural (Vaginal) ☐ Forceps/Vacuum ☐ Cesarean

Baby was born at _____ weeks Birth Weight _____

Complications during delivery:

_____

Length of stay in ☐ Nursery ☐ Neonatal Intensive Care (NICU): _____

Were there any problems while baby was in the hospital?

☐ Jaundice ☐ Breathing ☐ Infections ☐ Feeding Issues ☐ Episodes of apnea (not breathing) ☐ Surgery

Other: _____

Pass newborn hearing screening? ☐ Yes ☐ No

POSTNATAL HEALTH:

In the first 12 months, did baby have any of the following?

- ☐ **Excessively quiet / sleepy**
- ☐ **Excessively hyperactive or irritable**
- ☐ **Colicky**
- ☐ **Difficult to feed (poor suck, spitting up)**
- ☐ **Floppy muscle tone**
- ☐ **Stiff muscle tone**
- ☐ **Sleep problems**
- ☐ **Poor head control**
- ☐ **Poor eye contact**
- ☐ **Didn't like to be held or cuddled**
- ☐ **Difficult to calm down or comfort**
- ☐ **Abnormal response / interactions with people**

Other problems / concerns (explain):

_____

_____

Baby was breast feed until _____ bottle fed _____ until

Did parents have any problems with adjusting to new baby? ☐ Yes ☐ No

Serious injuries / accidents (drowning, calls to poison control, motor vehicle accidents):

_____

_____

Mark the box to any of the following issues the child has had:

- ☐ **Dental problems**
- ☐ **Does your child see a dentist**
- ☐ **Birth defects**
- ☐ **Heart problems**
- ☐ **Lung or breathing problems**
- ☐ **Constipation**
- ☐ **Diarrhea**
- ☐ **Nausea/ Vomiting**
- ☐ **Stomachache/pain/reflux**
- ☐ **Tics**
- ☐ **Tremors**
- ☐ **Hypotonia (low muscle tone/floppy)**
- ☐ **Hypertonia (tight muscles)**
- ☐ **Has child had an eye exam? ☐ Yes ☐ No**
- ☐ **Kidney/Urinary/Genital problems**
- ☐ **Chronic ear problems**
- ☐ **Long term use of antibiotics**
- ☐ **Easy bruising/bleeding/anemia**
- ☐ **Endocrine problems (e.g. thyroid)**
- ☐ **Skeletal/Bone problems (e.g. scoliosis)**
- ☐ **Environmental allergies**
- ☐ **Skin Problems (e.g. eczema)**
- ☐ **Sleep problems**
- ☐ **Migraines**
- ☐ **Toe Walking**
- ☐ **Staring spells**
- ☐ **Seizures**
- ☐ **Has child had a hearing test since birth?☐Yes☐No**

Hospitalizations (since birth)

Date	Age	Hospital	Reason

Surgeries

Date	Age	Hospital	Reason

Medications child is taking at this time

Medication	Amount (mg or volume)

Past medications taken

Medication	Period of Time	Helpful? (yes or no)

Dietary/Nutrition/Metabolic	Yes	No		Yes	No
Picky eater			Difficulty with solids		
Does child drink milk			Difficulty with liquids		
Eating/craving non-food items			Special diet		
Avoids specific food group			Dehydration needing hospitalization		
Reactions to specific foods			Anorexia/Bulimia		
Feeding issues in infancy					

DEVELOPMENTAL HISTORY

Have you ever worried that your child has lost skill that they used to have? ☐ **Yes** ☐ **No**

MOTOR	Age	Early	Normal	Late	NA
Crawled on hands and knees					
Walked with no help					
Pedaled a tricycle					
Rode a two-wheeled bicycle					
USE OF HAND/DAILY LIVING SKILLS					
Buttoned clothing					
Tied shoelaces					
Dressing / Undressing					
Handwriting					
RECEPTIVE LANGUAGE					
Smiled					
Understood name and / or the word “no”					
Followed a simple command					
Pointed to body parts (1-4)					
EXPRESSIVE LANGUAGE					
Babbled with repetitive vowels/consonants					
Said first word					
Spoke in tow word sentences					
Asked questions					

SCHOOL HISTORY

Current School: _____ **Phone:** _____ **Grade:** _____

Teacher (main classroom): _____ **Special Ed Teacher:** _____

Type of Class: ☐ **Regular** ☐ **Special Education** ☐ **504 Accommodation Plan**

Does your child receive any of the following services? If so, how many times and minutes per week? (e.g. 1x/day – 30 min/week)

☐ **Speech Therapy: At School?** _____ **In Community?** _____

☐ **Occupational Therapy: At School?** _____ **In Community?** _____

☐ **Physical Therapy: At School?** _____ **In Community?** _____

☐ **Counseling: At School?** _____ **In Community?** _____

Has child ever been retained a grade or held back? ☐ **No** ☐ **Yes (explain below)**

_____

_____

CHILD'S BEHAVIOR

Does your child have any of the following problems?

- ☐ **Attention/Focus**
- ☐ **Crying/Sadness**
- ☐ **Fears/Worries**
- ☐ **Fighting**
- ☐ **Impulsiveness**
- ☐ **Mood**
- ☐ **Obsessions/Compulsions**
- ☐ **Substance Abuse**
- ☐ **Talk of suicide**
- ☐ **Severe Transitions**
- ☐ **Unusual/Repetitive body movement**
- ☐ **Aggression to others:**
  _____
  _____
- ☐ **Self-Injury:**
  _____
  _____

FAMILY HISTORY

Are the birth mother and father related in any way (1st cousins, 2nd cousins, etc.)? ☐ **No** ☐ **Yes**

Does anyone in the family have any of the following? Check all that apply, past or present.

Condition	Mother	Father	Sibling	Mother's Family	Father's Family
Intellectual disability					
Learning disability					
Attention/ hyperactivity					
Depression					
Bipolar disorder					
Anxiety/OCD/ panic					
Schizophrenia					
Legal problems					
Alcohol or drug abuse					
Tics or Tourettes					
Autism					
Seizures/ epilepsy					
Genetic syndrome					
Cerebral palsy					
Cardiac problems					

SOCIAL HISTORY

PARENTS:

Parent 1's Name: _____ DOB: _____ Age: _____

Occupation: _____ Religion: _____

Highest grade completed: _____ Highest diploma: _____

Marital status: _____ Number of previous marriages: _____

Check which applies: ☐Biological/birth ☐Adoptive ☐Step ☐Foster ☐Other: _____

Parent 2's Name: _____ DOB: _____ Age: _____

Occupation: _____ Religion: _____

Highest grade completed: _____ Highest diploma: _____

Marital status: _____ Number of previous marriages: _____

Check which applies: ☐Biological/birth ☐Adoptive ☐Step ☐Foster ☐Other: _____

Family members' names and ages (mother, father, siblings):

Name	Age	Relationship to Patient	Living with Patient

Please check any of the boxes below that apply to the patient:

Foster care	**Lack of transportation**
Abuse (please circle type) physical sexual	**Witness to violence**
Neglect	**Fighting between patents ☐ verbal ☐ physical**
Legal problems (arrested or legal charges placed)	**Abandonment by one parent**
Death of parent or grandparent (How old was patient?) _____	**Litigation over custody/visitation**
Multiple moves	**Mental health diagnosis in one parent**
Separation from primary care giver? How long? _____	**Little support from family**
Divorce (How old was patient?) _____	**Economic hardship**
Homelessness (How long?) _____	**Unsafe living conditions**
Chronic medical condition	

Please list custody arrangements if divorced. Please list any pending custody litigation.