Neuroscience Specialists Of South Florida

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CHILD INTAKE FORM

I. PATIENT INFORMATION

Name of the Child ____

Date of Birth ___________________ Age__________ Person completing Form __________________

Home Phone Number: ____

Primary Care Provider (Include Office Number):

____

Behavioral Health Provider (Include Office Number):

____

II. CONCERNS

What are the concerns you have about your child?

____
____
____
____
____
____

How long has this problem been a concern?

____

When did you first notice this problem?

____

Who else have you seen for this problem?

____

What evaluations have already been performed? Please bring copies if possible.

____
____

What has already been done to treat this problem (example: medications, diet, counseling, testing) ?

____
____

What have you done, personally, to address these problems?

____
____

What seems to help the most?

____
____

III. PREGNANCY

During Pregnancy, did the biological mother have any of the following: *(Please circle all that apply)*

Aminocentesis	High Blood Pressure	Vaginal Bleeding
Anemia	High Fevers	Vaginal Infection
Diabetes	Kidney Problems	Other Infections
Emotional Problems	No Prenatal Care	Other:
Excessive Weight Gain	Placenta Previa	____________________
German Measles	Premature Labor	____________________
		____________________

During the Pregnancy, did the mother use: *Please circle all that apply*

Medications   Street Drugs   Alcohol   Tobacco

Were there any other complications during pregnancy?

____

____

____

____

IV. DELEVERY

How old was the mother at time of delivery? ______________________________________

____

What number pregnancy was this? ______________________________________

____

How many older living children are there? ______________________________________

____

How long did the pregnancy last? ______________________________________

____

Where was the baby born? ______________________________________

How long was the labor? *Please circle one.*

Less than 4 hours   4-12 hours   12-24 hours   More than 24 hours

Delivery was by: (*Please circle one)*

Cesarean Section: Planned   Emergency

Vaginal: Forceps   Vacuum   No Assistance

Was anesthesia used?   Yes   No

V. POST NATAL

Baby's Birth Weight ________ pounds _______ ounces

Did the Baby have any of the following: *(Please circle all that apply)*

Anemia	Fever/Low Temp	Physical Injuries	Use of Oxygen
Apena	Hernia	Seizures	Ventilator
Birth Defects	Hydrocephalus	Surfacant	Other:
Blood Transfusion	Infection	Trouble Breathing	________________
Braycardia	Intensive care	Phyical Injuries	________________
Cord Around Neck	Intracranial Bleed	Trouble Suckling	________________
Eye Problems	Jitteriness	Jaundice	________________
			________________
			________________

Was the baby: *(Please circle all that apply)*

Breast Fed? No Yes If yes, for how long ________________________________

Bottle Fed? No Yes If yes, for how long ________________________________

Are Immunizations up to date? No Yes

Has your child had any of the following? *(Please circle all that apply.)*

1) Blood Disorders:
   - Anemia
   - Bleeding
   - Bruising
2) Brain Disorders:
   - Confusion
   - Staring
   - Headaches
   - Tremors
   - Coordination Problems
   - Tics (motor/vocal)
   - Muscle Weakness
3) GI Problems:
   - Constipation
   - Soiling
   - Diarrhea
   - Vomiting
4) Heart/Lung Problems:
   - Asthma
   - Surgery
   - Chest Pain
   - Congenital Heart Disease
   - Murmur
5) Hormone Problems:
   - Obesity
   - Early/late puberty
   - Thyroid

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6) Infections:
   - Chicken Pox
   - Whooping Cough
   - Measles
   - Encephalitis
   - Sinus Infections
   - Mumps
   - Ear Infections
   - High Fevers
   - Meningitis
   - Pneumonia
7) Injuries:
   - Broken Bones
   - Stiches
   - Head Injury
8) Kidney Problems:
   - Bed Wetting
   - Infections
   - Daytime Wetting
9) Muscle/Bone Problems:
   - Scoliosis
   - Other: ___________________
   - Spasticity
10) Poisoning:
   - Chemicals
   - Other: ___________________
   - Lead
11) Sensory Problems:
   - Hearing
   - Vision
   - Tactile
12) Sexual Problems:
   - Birth Control
   - Promiscuity
   - Masturbation
13) Skin Disorders:
   - Acne
   - Eczema
   - Birth Marks
   - Hair Loss
14) Any Burns: ____
15) Drug Allergies: ____
16) Past Medications: ____
17) Present Medications: ____
18) Surgeries: ____
19) Special Diagnostic Tests: (MRI, CT, SPECT, etc) ____________________________________
20) Nutritional Assessment:

    Current Weight: ____________ Current Height: __________Appetite: Good Fair Poor

    If Poor Please Explain: ____

    Any special dietary needs? Hiding/Hording Food? Any food allergies? __________________

    ____

21) Trauma History:

    Has the child ever been a victim of physical, emotional, or sexual abuse?

    Yes No ____

    If Yes, would it be okay to discuss this further with you?

    Yes No ____

VI. DEVELOPMENT

At what age did your child first: *(Fill in age or check those that apply)*

	Age	Early	Not sure/ On Time	late
Sit Up				
Crawl				
Walk				
Ride A Tricycle				
Ride A Bicycle				
Say Mama/Dada				
Use two word sentences				
Use three word sentences				
Speak intelligibly				
Give up the bottle				
Use a cup				
Finger Food				
Use a spoon				
Use a fork				
Dress Self				
Toilet Trained				
Tie Shoes				
Brush Teeth				

Do you have any concerns about your child's motor or muscle development?

____
____
____
____

Does your child have any sleeping problems (falling asleep, staying asleep, nightmares, sleeping, walking, etc.)? ____

____
____
____

Please circle all that apply to your concerns about your child's language development.

Trouble finding the right words
Unconnected thoughts
Speech clarity
Stuttering
Has seen a speech therapist
Too few words in sentences
Repeat words over and over
Following directions

VII. CHILD'S STRENGTHS

What are your child's most outstanding characteristics (hobbies, achievements, abilities, etc.)?

____
____
____
____
____

VIII. SCHOOL HISTORY

Name of School: ____

Current Grade: ________________________ Teacher's Name: ________________________

Child's Classroom: *(please circle one)*

Regular Special Education/Self Contained Regular with Resource Help

What is your impression of your child's learning potential? *(please circle one)*

Low Average Above Average Gifted

Do you feel that your child is performing up to his/her potential in school? Yes No

Do you feel your child has difficulties with: *(please circle all that apply)*

Math Science Languages

Social Studies Reading Writing

Is your child's school experience made difficult by problems with: *(check all that apply)*

	Not At All	Somewhat	A Lot
Poor Concentration			
Giving Up Easily			
Inconsistent Performance			
Poor Motivation			
Disorganization			
Spacing Out or Day Dreaming			
Not Finishing Things			
Low Frustration Tolerance			
Anxiety/Saddness			
Poor Handwriting			
Rapidly Shifting from one thing to another			

Is Homework a Problem? No Yes Explain *(Please circle all that apply)*

Cannot Get Started
No Place to Work
Forgets Assignments
Does not anticipate deadlines
Takes too long
Forgets to bring home materials

Does not understand the work
Gets distracted by (TV, Radio, Other)
Battles/argues about doing the work
This is the most stressful time of day
Needs you by his/her side constantly

Has your child ever been: *(Please circle all that apply)*

Retained Suspended Expelled Advanced a Grade

IX. SOCIAL

Does your child get along well with others? Yes No

Please check the box that best describes the frequency of the behavior.

	A Lot	Sometimes	Rarely	Never
Makes friends easily				
Plays well with others				
Has a best friend				
Shares easily				
Follows rules				
Enjoys team sports				
Leads other children				
Helps others				
Is easily influenced				
Prefers to be alone				
A party animal				
Bullies others				
Fights more than others				

X. SELF-ESTEM

Please check the box that best describes the frequency of the behavior.

	A Lot	Sometimes	Rarely	Never
Have an "I can do it" attitude				
Give up easily				
Stand up for self				
Recover from upsets				
Recognize strengths				
Lack Confidence				
Act Adventuresome				

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XI. BEHAVIORAL HEALTH HISTORY

Has your child or any sibling received psychiatric or psychological treatment?

Does your child have any of the following **attention** related problems? *(please check all that apply)*

	A Lot	Sometimes	Rarely	Never
Fidgets				
Easily Distracted				
Often blurts out answers				
Difficulty sustaining attention				
Difficulty playing quietly				
Often interrupts or intrudes on others				
Often loses things				
Difficulty awaiting turn				
Difficulty following instructions				
Shifts from one activity to another				
Often does not listen				
Often engages in physical dangerous activity				

Does your child have any of the following **oppositional** concerns? *(please check all that apply)*

	A Lot	Sometimes	Rarely	Never
Often loses temper				
Often argues with adults				
Often actively defies or refuses adult request/rules				
Often deliberately does things that annoy other people				
Often blames others for own mistakes				
Is often touchy or easily annoyed by others				
Is often angry or resentful				
Is often spiteful or vindictive				
Often swears or uses obscene language				

Does Your child engage in the following behavior problems?

	A Lot	Sometimes	Rarely	Never
Excessive distress when actually separated from you or home				
Unrealistic worry about future events				
Unrealistic concern about competence				
Marked Self-Consciousness				
Excessive need for reassurance				
Marked inability to relax				

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Does your child show: *Please check the box that best describes the frequency of the behavior*

	A Lot	Sometimes	Rarely	Never
Depressed or irritable mood most of the day				
Diminshed pleasure in activities				
Agitation or sluggishness				
Feelings or worthlessness or excessive inappropriate guilt				
Poor appetite or overeating				
Trouble sleeping or sleeps too much				
Low energy or fatigue				
Low self-esteem				
Poor concentration or difficulty making decisions				
Feelings of hopelessness				

Does your child have any of the following concerns?

Please check the box that best describes the frequency of the behavior

	A Lot	Sometimes	Rarely	Never
Repeated unusual movements				
Odd postures				
Excessive reaction to noise or fails to react to loud noises				
Overreacts to touch				
Compulsive rituals				
Motor tics				
Vocal tics				

Has your child exhibited any of the following symptoms of thought or disturbance?

Please check the box that best describes the frequency of the behavior

	A Lot	Sometimes	Rarely	Never
Cannot get to the point, Loses train of thought				
Bizarre ideas, disoriented, confused, staring, spacey				
Incoherent speech				

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Please check the box that best describes the frequency of the behavior

	A Lot	Sometimes	Rarely	Never
Stolen without confrontation				
Ran away from home overnight at least twice				
Lies often				
Deliberate fire setting				
Often truant				
Breaking and entering				
Destroys others property				
Cruel to animals				
Forces someone else into sexual activity				
Used a weapon in a fight				
Often initiates physical fights				
Stolen with confrontation				
Physically cruel to people				

Does your child show any of the following anxiety related symptoms?

Please check the box that best describes the frequency of the behavior

	A Lot	Sometimes	Rarely	Never
Unrealistic and persistent worry that something will happen to you				
Persistent school refusal				
Ongoing refusal to sleep alone				
Avoidance of being along				
Repeated nightmares about separation from you				
Physical aches and pain				

Has your child exhibited any of the following symptoms?

Please check the box that best describes the frequency of the behavior

	A Lot	Sometimes	Rarely	Never
Excessive mood swings				
Explosive temper with minimal provocation				
Excessive clinging, attachment, or dependence on adults				
Unusual fears				
Panic attacks				
Excessively monotonous or bland affect				
Situationally inappropriate emotions				

Has your child exhibited any of the following social concerns?

Please check the box that best describes the frequency of the behavior

	A Lot	Sometimes	Rarely	Never
Little or no interest in peers and friends				
Significant indiscreet remarks				
Initiates or terminates interactions inappropriately				
Abnormal social behavior				
Excessive reaction to changes in routine				

XII. FAMILY MEDICAL HISTORY

Please circle all that apply in your family:

Alcoholism	Emotional Problems	Mental Retardation
Blind	Epilepsy	Sickle Cell Anemia
Cerebral Palsy	Heart Problems	Sugar Diabetes
Deaf	High Blood Pressure	Tuberculosis
Drug Abuse	Learning Problems	Other: ________________

Is there any parental history of similar problems with school, behavior, learning and reading?

____

____

XIII. FAMILY PSYCHIATRIC HISTORY

Is there a history of behavioral health illness (such as bipolar disorder, depression, panic attacks, alcoholism, drug addiction, schizophrenia, etc..) in any extended family member?

Relationship to Patient	Specific Behavioral Health Illness

XIV. FAMILY SOCIAL HISTORY

FATHER

NAME: ________________________________

AGE: _________________________________

EDUCATION: __________________________

EMPLOYMENT: ________________________

PART TIME FULL TIME

MOTHER

NAME: ________________________________

AGE: _________________________________

EDUCATION: __________________________

EMPLOYMENT: ________________________

PART TIME FULL TIME

Parents are currently: *(please check one)*

□ Married □ Widowed □ Single

□ Divorced □ Separted

Child lives with: ____

Who provides care for the child? ____

Names of Siblings:

Name	Age	Grade	Problems

What is the child's fit within the family? *(please check all that apply)*

□ Sibling rivalry □ A team player

□ Spoiled, always gets own way □ A manipulator

□ A rescuer, can stand upsets □ A helper

Do any of the following stressors apply to your family? *(please check all that apply)*

□ Parental separation □ Financial stress □ Change of job

□ Severe illness □ Death of a family member or friend □ Pregnancy/birth of a new child

□ Change of school □ Move to a new home

Cultural/Ethnic/Tribal Identity: ____

Does your Child/Family participate in spiritual or religious activities? ____________________________

XV. DISCIPLINE

What types of discipline are used in your family? *(please check all that apply)*

□ Discussion and education

□ Encouragement of independent thinking

□ Spanking

□ Contracts and token systems

□ Positive rewards and praise

□ Time-out

□ Restrictions and grounding

□ Lecturing/Nagging/Screaming

____ ________________________

Signature of Parent or Legal Guardian Date Completed