St Luke's
Developmental Pediatrics

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New Patient Intake Form

Demographics

Date:_____

Child's Legal Name:_____ Childs Age:_____ Date of Birth:_____Gender:____

Preferred Language:_____Written Language: _____Interpreter Needed?_____

Race: _____ Ethnicity: _____Religion: _____

Child's Address: _____ County: _____

Primary Phone number: _____ Email Address:_____

Who are the Legal Guardian(s) of the child?:

☐ Mother ☐ Father ☐ Other (please specify):_____

Parent/Guardian Marital Status : ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Widowed

Are there any custody issues or orders of protection of which we should be aware? (Copy of court orders required- send copy to office) ☐ Yes* ☐ No

Parent/Guardian 1:

Last name_____First Name_____ DOB:_____

Highest School Level Completed:_____

Employed: ☐ Full-Time ☐ Part-Time ☐ Other Employers Name:_____

Parent/Guardian 2:

Last name_____First Name_____ DOB:_____

Highest School Level Completed:_____

Employed: ☐ Full-Time ☐ Part-Time ☐ Other Employers Name:_____

Family Composition

Please check those with whom the child lives (Write in names):

☐ Biological Mother: _____ ☐ Biological Father: _____
☐ Step-Mother: _____ ☐ Step-Father: _____
☐ Adoptive Mother: _____ ☐ Adoptive Father: _____
☐ Grandmother: _____ ☐ Grandfather: _____
☐ Guardian(s): _____ ☐ Other(s): _____
☐ Siblings (specify half/step/full): _____
_____

Biologic Family Medical and Psychiatric History

Does anyone in this child's biologic family have:	**Yes**	**No**	**Relationship to the child? Please specify maternal or paternal (i.e paternal uncle)**
ADHD/ADD or Attentional Issues			
Alcohol or Drug Abuse			
Arrhythmia or heart problems before age 50- **if yes, specify**			
Autism Spectrum Disorder			
Behavior Problems or Trouble with the law			
Birth Defects			
Developmental Delays (late walker/talker)			
Diabetes			
Emotional, Physical, or Sexual Abuse			
Genetic Diagnosis			
Hearing Loss or Vision Loss (glasses)			
Intellectual Disability (formerly mental retardation)			
Learning Difficulties or disability (reading, writing, math, etc.)			
Obesity			
Mental health disorders such as anxiety, depression, obsessive compulsive disorder, bipolar, schizophrenia- **if yes, specify**			
Seizures/epilepsy			
Sudden Death before Age 50			
Tics/Tourette's Syndrome			
Other Conditions/Diagnoses – **specify**			

Reason for Visit

How old was your child when concerns began?_____

Parental Concerns
What are your top 3 concerns regarding your child?
1.
2.
3.
What are your child's top 3 strengths?
1.
2.
3.

Professional Evaluations					
Has your child previously been evaluated by any of the following providers? (Please check all that apply and **provide copies of reports**):					
	Previous Evaluations		Provider Name	Evaluation Date	Diagnosis
Developmental Pediatrician (CHOP, LVPG, St Christopher, other)	☐ Yes	☐ No			
Neurologist	☐ Yes	☐ No			
Psychiatrist	☐ Yes	☐ No			
Psychologist	☐ Yes	☐ No			
Speech Therapist	☐ Yes	☐ No			
Occupational Therapist	☐ Yes	☐ No			
Physical Therapist	☐ Yes	☐ No			
Behavior Therapist (KidsPeace, Pine Brook, Progressions, PA Mentor, Access, etc.)	☐ Yes	☐ No			
Other (Gastroenterology, Pulmonology, Vision, ENT, Audiology, Cardiology, Endocrine Orthopedics, Orthotics etc.)	☐ Yes	☐ No			
Mental Health Counselor	☐ Yes	☐ No			
Genetics	☐ Yes	☐ No			

Medication History					
Is your child currently taking, or have they previously taken, any supplements or medications for *inattention, anxiety, behavior, mood or sleep?*			☐ Yes*	☐ No	
*If yes, please list **all medications and supplements** your child is **currently taking or has tried**					
Name of Medication	**Reason for taking**	**Dosage**	**Frequency**	**Period taken**	**Prescribed by whom?**

Medical History			
Has your child had any previous medical testing completed including, but not limited to, EEG, MRI, CT scan, EKG, genetic or metabolic testing, etc.? ☐ Yes ☐ No			
Year	**Type of Testing**	**Where was it done?**	**Results**

Lead Testing

Any history of elevated lead level? ☐Yes ☐No If yes, peak level_____Date:_____

Hearing Testing

Passed newborn hearing screen? ☐ Yes ☐ No

Has child passed hearing screens through doctor or school? ☐ Yes ☐No

Has formal hearing testing even been done at speech/hearing center or ENT? ☐Yes ☐No

If yes, date done:_____

Has your child had any previous hospitalizations or surgeries? ☐ Yes ☐ No *if yes, specify below		
Date	**Reason**	**Location**

Pregnancy and Newborn History			
	Yes	**No**	**Comment**
Age of mother when child was born ____ years			
Baby was born at ____ weeks			
Birth weight? ____Lbs. ____oz.			
Is this child a twin or triplet?	☐	☐	
Any problems with other pregnancies? Miscarriages?	☐	☐	
Used *in vitro fertilization* or other method of conception?	☐	☐	
Were there any problems during *this* pregnancy?	☐	☐	
Were any medications prescribed during pregnancy? Why?	☐	☐	
Did mother have gestational diabetes (sugar in urine), high blood pressure, toxemia, or infections (including herpes) during pregnancy?	☐	☐	
Any smoking, alcohol consumed (beer, wine, etc.), or street drugs (marijuana, cocaine, etc.) used during pregnancy? (	☐	☐	
Any problems during labor or delivery?	☐	☐	
Cesarean delivery? Why?	☐	☐	
Were there any problems at birth or as a newborn?	☐	☐	
Were any birth defects or birth injuries noted?	☐	☐	
Put in special care or intensive care nursery/NICU? *If yes how many days? ____	☐	☐	
Did baby have jaundice and need phototherapy?	☐	☐	
Was baby very jittery or lethargic as a newborn?	☐	☐	
Did baby have to stay extra days in the hospital? *If yes how many days?____	☐	☐	

Infant Temperament			
As an infant/toddler did your child have any of the following?			
	Yes	**No**	**Comment**
Feeding difficulties	☐	☐	
Prolonged colic or excessive crying	☐	☐	
Extreme irritability	☐	☐	
A loose or floppy body	☐	☐	
Excessive body movements (wiggly or active)	☐	☐	
Easily over-stimulated	☐	☐	
Was shy or withdrawn	☐	☐	
A dislike of being held or cuddled	☐	☐	

Current or Past Medical Symptoms			
Has your child ever had, or do they currently have, any of the following medical symptoms?			
	Yes	**No**	**Comments**
Serious illness or infection	☐	☐	
Serious injury, (burns, broken bones, concussion, etc)?	☐	☐	
Abnormal growth (too small/ large)	☐	☐	
Seizures, staring spells, convulsions	☐	☐	
Frequent headaches/ fainting/ dizzy episodes	☐	☐	
Respiratory or lung problems	☐	☐	
Heart problems or arrhythmias	☐	☐	
Unexplained vomiting or reflux	☐	☐	
Unusual reaction to immunizations	☐	☐	
Are immunizations up to date	☐	☐	
Known genetic problems	☐	☐	
Low tone or spasticity (rigid/stiff body)	☐	☐	
Birth marks or skin problems	☐	☐	
Tooth issues or cavities	☐	☐	
Difficulties with bowel movements	☐	☐	
Daytime urinary incontinence (‘wets’ pants)	☐	☐	
Abnormal movements	☐	☐	
Thyroid or hormone problems	☐	☐	
Frequent ear infections and/or tubes?	☐	☐	

Development History		
	Approximate Age Accomplished	**Too Young**
Sat without support		☐
Walked		☐
Spoke first words (except mama/dada)		☐
Spoke in two-three word sentences		☐
Toilet trained during the day		☐
Dry at night		☐
Able to dress self		☐
Rode a tricycle		☐
Read simple words		☐
Able to tie shoes		☐
Has your child ever had a regression in skills (loss of previously acquired skills) outside of those that occur during breaks from school? ☐Yes ☐ No If yes, please explain.		

Sleep History and Screen Time			
	Yes	**No**	**Comments**
Does your child have trouble falling asleep?	☐	☐	
Does your child have trouble staying asleep?	☐	☐	
Does your child have any night terrors or sleep walking?	☐	☐	
Does your child snore?	☐	☐	
Is there a TV in the bedroom and/or does your child have screentime within two hours of sleep	☐	☐	
How many hours per day does your child use electronic devices with screens (cellphone, tv)			

Nutrition/Diet			
	Yes	**No**	**Comments**
Any history of or current feeding/eating difficulties?	☐	☐	
Does the child eat from all food groups (meat/protein, dairy, complex carbohydrates, fruits, vegetables)?	☐	☐	
Any special dietary modifications?	☐	☐	
Takes any vitamins or supplements?	☐	☐	
How many cups of milk are consumed daily?			
Please indicate the types of foods that your child currently consumes (select all that apply): ☐ Bottle fed ☐ Soft Foods ☐ Crunchy or textured foods ☐ Pureed Foods ☐ Table food/solids			

Safety			
	Yes	**No**	**Please explain**
Does child place non-food items in mouth?	☐	☐	
Does child wander/elope?	☐	☐	
Is the home child-proofed?	☐	☐	
Does anyone smoke or use e-cigarettes in the home (including basement) or car?	☐	☐	
Are there any guns in the home?	☐	☐	
Are the guns stored in a locked place?	☐	☐	
Are bullets stored separately from guns?	☐	☐	
Is the child exposed to yelling or physical violence in the home?	☐	☐	
Has the child ever experienced abuse (emotional, physical, and/or sexual)?	☐	☐	

Tantrums			
	Yes	**No**	**Comments**
Does your child have frequent tantrums (e.g., emotional outbursts that range from yelling to aggression)	☐	☐	
If yes, Average frequency: _____ per day / _____ per week			
Average duration: ___ minutes, Longest duration: ___ minutes			
Common triggers:			
What helps your child to calm?			

Are you concerned about any of the following? (Check all that apply):	
Speech delay (ex: make sounds, babble, understand words, say words)	☐
Fine motor delay (ex: grab or hold items in hands)	☐
Social difficulties (ex: smile, play, point, gestures)	☐
Gross motor delay (ex: roll, sit, crawl, walk)	☐
Moodiness or irritability, anxious child	☐
Situational stressors (ex: family changes, neglect, abuse)	☐
Sleep difficulties	☐
Behavioral challenges (aggression, hyperactive)	☐
Abnormal movements	☐
Feeding difficulty	☐

Day Care Information		
Does your child attend daycare/homecare? ☐ Yes ☐ No		
Name of Current Day Care:		
Address:		
Contact numbers:	Phone:	Fax:
Teacher Name(s):		
Has your child ever been expelled or suspended? ☐Yes ☐ No If yes, please describe the circumstances:		

Early Intervention	
Has your child been evaluated by Early Intervention?	☐ Yes ☐ No **If yes, age at evaluation:** _____
****If yes, we will require a copy of the Evaluation Report and IFSP**	

Does your child currently receive any of the following support services? Please check all that apply			
☐	Case management	☐	Special Instruction (SEIT)
☐	Speech therapy	☐	Early Head Start
☐	Occupational Therapy	☐	Children and Youth (CYS)
☐	Physical Therapy	☐	Services for the Deaf
☐	Services for the Blind	☐	Other: