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New Patient Intake Form

Demographics

Date: _____
Child's Legal Name: _____ Childs Age: _____
Date of Birth: _____ Sex assigned at birth: _____
Preferred Language: _____ Written Language: _____ Interpreter Needed? _____
Race: _____ Ethnicity: _____ Religion: _____
Child's Address: _____ County: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Email Address: 1. _____ 2. _____

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):

- | | |
|---|---|
| <input type="checkbox"/> Biological Mother: _____ | <input type="checkbox"/> Biological Father: _____ |
| <input type="checkbox"/> Step-Mother: _____ | <input type="checkbox"/> Step-Father: _____ |
| <input type="checkbox"/> Adoptive Mother: _____ | <input type="checkbox"/> Adoptive Father: _____ |
| <input type="checkbox"/> Grandmother: _____ | <input type="checkbox"/> Grandfather: _____ |
| <input type="checkbox"/> Guardian(s): _____ | <input type="checkbox"/> Other(s): _____ |
| <input type="checkbox"/> 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			

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?	<input type="checkbox"/>	<input type="checkbox"/>	
Any problems with other pregnancies? Miscarriages?	<input type="checkbox"/>	<input type="checkbox"/>	
Used <i>in vitro fertilization</i> or other method of conception?	<input type="checkbox"/>	<input type="checkbox"/>	
Were there any problems during <i>this</i> pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Were any medications prescribed during pregnancy? Why?	<input type="checkbox"/>	<input type="checkbox"/>	
Did mother have gestational diabetes (sugar in urine), high blood pressure, toxemia, or infections (including herpes) during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Any smoking, alcohol consumed (beer, wine, etc.), or street drugs (marijuana, cocaine, etc.) used during pregnancy? (<input type="checkbox"/>	<input type="checkbox"/>	
Any problems during labor or delivery?	<input type="checkbox"/>	<input type="checkbox"/>	
Cesarean delivery? Why?	<input type="checkbox"/>	<input type="checkbox"/>	
Were there any problems at birth or as a newborn?	<input type="checkbox"/>	<input type="checkbox"/>	
Were any birth defects or birth injuries noted?	<input type="checkbox"/>	<input type="checkbox"/>	
Put in special care or intensive care nursery/NICU? *If yes how many days? ____	<input type="checkbox"/>	<input type="checkbox"/>	
Did baby have jaundice and need phototherapy?	<input type="checkbox"/>	<input type="checkbox"/>	
Was baby very jittery or lethargic as a newborn?	<input type="checkbox"/>	<input type="checkbox"/>	
Did baby have to stay extra days in the hospital? *If yes how many days? ____	<input type="checkbox"/>	<input type="checkbox"/>	

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

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

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	<input type="checkbox"/>	<input type="checkbox"/>	
Serious injury, (burns, broken bones, concussion, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal growth (too small/ large)	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures, staring spells, convulsions	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent headaches/ fainting/ dizzy episodes	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems or arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	
Unexplained vomiting or reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Unusual reaction to immunizations	<input type="checkbox"/>	<input type="checkbox"/>	
Are immunizations up to date	<input type="checkbox"/>	<input type="checkbox"/>	
Known genetic problems	<input type="checkbox"/>	<input type="checkbox"/>	
Low tone or spasticity (rigid/stiff body)	<input type="checkbox"/>	<input type="checkbox"/>	
Birth marks or skin problems	<input type="checkbox"/>	<input type="checkbox"/>	
Tooth issues or cavities	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulties with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	
Daytime urinary incontinence ('wets' pants)	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal movements	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid or hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent ear infections and/or tubes?	<input type="checkbox"/>	<input type="checkbox"/>	

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, Geisinger, Hershey other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Neurologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Psychiatrist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Psychologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Speech Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Occupational Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Physical Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Behavior Therapist (KidsPeace, Pine Brook, Progressions, PA Mentor, Access, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Other Specialists (Gastroenterology, Pulmonology, Vision, ENT, Audiology, Cardiology, Endocrine Orthopedics, Orthotics etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Mental Health Counselor	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Genetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Other (Black Bird, Easter Seals, Meliora, Glenn Koch)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Medication History					
Is your child currently taking, or have they previously taken, any supplements or medications for <i>inattention, anxiety, behavior, mood or sleep</i> ?				<input type="checkbox"/> Yes*	<input type="checkbox"/> 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?
Are you seeking consultation for medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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.? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Year	Type of Testing	Where was it done?	Results
Lead Testing			
Any history of elevated lead level? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, peak level _____ Date: _____			
Hearing Testing			
Passed newborn hearing screen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has child passed hearing screens through doctor or school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has formal hearing testing even been done at speech/hearing center or ENT? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, date done: _____			

Hospitalizations/Surgical History		
Has your child had any previous hospitalizations or surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*if yes, specify below		
Date	Reason	Location

Sleep History and Screen Time			
	Yes	No	Comments
Where does your child sleep?			
Does your child have trouble falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have trouble staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have any night terrors or sleep walking?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child snore?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a TV in the bedroom and/or does your child have screentime within two hours of sleep	<input type="checkbox"/>	<input type="checkbox"/>	
How many hours per day does your child use electronic devices with screens (tablet, cellphone, tv, computer, video games, etc)			

Nutrition/Diet			
	Yes	No	Comments
Any history of or current feeding/eating difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the child eat from all food groups (meat/protein, dairy, complex carbohydrates, fruits, vegetables)?	<input type="checkbox"/>	<input type="checkbox"/>	
Any special dietary modifications?	<input type="checkbox"/>	<input type="checkbox"/>	
Takes any vitamins or supplements?	<input type="checkbox"/>	<input type="checkbox"/>	
Please indicate the types of foods that your child currently consumes (select all that apply): <input type="checkbox"/> Bottle fed <input type="checkbox"/> Soft Foods <input type="checkbox"/> Crunchy or textured foods <input type="checkbox"/> Pureed Foods <input type="checkbox"/> Table food/solids			

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

Tantrums and Behavior Management			
	Yes	No	Comments
Does your child have frequent tantrums (e.g., emotional outbursts that range from yelling to aggression)	<input type="checkbox"/>	<input type="checkbox"/>	
How many tantrums per day? _____ Per week? _____			
How long do tantrums last on average? _____ mins How long do tantrums last at their worst? _____ mins			
Common triggers:			
What helps your child to calm?			
Have you tried any of the following?:			
Time Out <input type="checkbox"/> Ignoring <input type="checkbox"/> Redirection <input type="checkbox"/> Earning Privileges <input type="checkbox"/> Taking away privileges <input type="checkbox"/>			
Yelling <input type="checkbox"/> Spanking <input type="checkbox"/> Giving more chores <input type="checkbox"/>			

Learning and Behavioral Symptoms			
My Child is Able To (select all that apply):			
Speak clearly <input type="checkbox"/>	Understand jokes and sarcasm (be silly) <input type="checkbox"/>		
Write legibly, draw <input type="checkbox"/>	Self-sooth or be consoled <input type="checkbox"/>		
Run and move around easily <input type="checkbox"/>	Be empathetic/kind to others <input type="checkbox"/>		
Dress and feed themselves <input type="checkbox"/>	Play with other children/make friends <input type="checkbox"/>		
Understand social cues/body language <input type="checkbox"/>	None of the above <input type="checkbox"/>		
Comment:			
My Child Can Be Described As (select all that apply):			
Anxious <input type="checkbox"/>	Generally calm <input type="checkbox"/>		
Hyperactive & Impulsive <input type="checkbox"/>	Sensitive to sensory input (sights, smells, touch, sounds) <input type="checkbox"/>		
Emotionally reactive <input type="checkbox"/>	Strong-willed <input type="checkbox"/>		
Moody or depressed <input type="checkbox"/>	Inattentive <input type="checkbox"/>		
Shy or slow-to-warm up <input type="checkbox"/>	Mostly pleasant <input type="checkbox"/>		
Persistent & Demanding <input type="checkbox"/>	None of the above <input type="checkbox"/>		
Comment:			
My Child Shows an Understanding of (select all that apply):			
Shapes <input type="checkbox"/>	Letters <input type="checkbox"/>		
Colors <input type="checkbox"/>	Reading <input type="checkbox"/>		
Numbers <input type="checkbox"/>	Writing (not fine motor issues) <input type="checkbox"/>		
Counting <input type="checkbox"/>	Math <input type="checkbox"/>		
None of the above <input type="checkbox"/>	Comment:		

My Child Has Difficulty With (select all that apply):	
Paying attention to people talking <input type="checkbox"/>	Change in routine <input type="checkbox"/>
Holding a conversation <input type="checkbox"/>	Responding to their name <input type="checkbox"/>
Understanding tone of voice <input type="checkbox"/>	None of the above <input type="checkbox"/>
Using eye contact <input type="checkbox"/>	Comment:
I Have Concerns for My Child's (select all that apply):	
Understanding of spoken words <input type="checkbox"/>	Unnecessarily organizing <input type="checkbox"/>
Ability to retain information <input type="checkbox"/>	Repetitive behaviors/actions <input type="checkbox"/>
Self-injurious behaviors (hitting/biting/scratching/head banging) <input type="checkbox"/>	Ability to play with toys, sharing, taking turns (using toys appropriately/imaginative play) <input type="checkbox"/>
Ability to communicate with words or gestures <input type="checkbox"/>	Ability to make friends <input type="checkbox"/>
Poor self esteem <input type="checkbox"/>	Literal or concrete thinking <input type="checkbox"/>
Use of odd language <input type="checkbox"/>	Abnormal reaction to pain <input type="checkbox"/>
None of the above <input type="checkbox"/>	Comment:
My Child is Frequently (select all that apply):	
Repeating words/phrases previously heard <input type="checkbox"/>	<input type="checkbox"/>
Focused on unusual topics or items <input type="checkbox"/>	Collecting odd items <input type="checkbox"/>
Making negative comments <input type="checkbox"/>	Refusing to go to school <input type="checkbox"/>
Refusing/struggling to complete school work <input type="checkbox"/>	Talking about hurting themselves or others <input type="checkbox"/>
Comment:	

Daycare Information
Does your child attend daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide the name of the daycare and dates attended:

Preschool/Pre-K Information
Does your child attend preschool/Pre-K? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide all school names and dates attended:
Current Preschool/Pre-K:
Teacher Name(s):
Has your child ever been expelled or suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe the circumstances: _____

Has your child ever been evaluated by the following?:		Age at Evaluation	
Early intervention	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Intermediate Unit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does your child have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide a copy to office)			
Does your child currently receive any of the following support services? Please check all that apply:			
<input type="checkbox"/> 1:1 Aide	<input type="checkbox"/> Special Instruction		
<input type="checkbox"/> Interpreter	<input type="checkbox"/> Speech Therapy		
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> BHRS (BSC/TSS)		
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other (specify):		

Home Situations Questionnaire

St. Luke's Developmental Pediatrics

Instructions: Does your child present any problems with compliance to instruction, comments or rules for you in any of these situations? If so, please circle the word YES and then circle a number beside that situation that describes how severe the problem is for you. If your child is not a problem in a situation, circle NO and go to the next situation on the form.

Situation	Problem Present?		How Severe?								
			Mild			Moderate			Severe		
Playing Alone	No	Yes	1	2	3	4	5	6	7	8	9
Playing with other children	No	Yes	1	2	3	4	5	6	7	8	9
Meal times	No	Yes	1	2	3	4	5	6	7	8	9
Getting dressed/undressed	No	Yes	1	2	3	4	5	6	7	8	9
Washing and bathing	No	Yes	1	2	3	4	5	6	7	8	9
When you are on the telephone	No	Yes	1	2	3	4	5	6	7	8	9
When visitors are in your home	No	Yes	1	2	3	4	5	6	7	8	9
When you are visiting someone's home	No	Yes	1	2	3	4	5	6	7	8	9
In public places	No	Yes	1	2	3	4	5	6	7	8	9
When father is home (<input type="checkbox"/> check if not applicable)	No	Yes	1	2	3	4	5	6	7	8	9
When asked to do chores	No	Yes	1	2	3	4	5	6	7	8	9
When asked to do homework	No	Yes	1	2	3	4	5	6	7	8	9
At bedtime	No	Yes	1	2	3	4	5	6	7	8	9
When with a babysitter	No	Yes	1	2	3	4	5	6	7	8	9

ADHD Rating Scale IV – Preschool / Daycare Version (Parent)

Circle the number that best describes the child’s behavior over the past 6 months	Rarely or never	Sometimes	Often	Very Often
1. Fails to give close attention to details (i.e. rushes through activities, makes careless mistakes)	0	1	2	3
2. Fidgets with hands or feet or squirms in seat (taps hands or feet)	0	1	2	3
3. Has difficulty sustaining attention in tasks or play activities	0	1	2	3
4. Leaves seat in classroom, during meals, or in other situations in which remaining seated is expected	0	1	2	3
5. Does not seem to listen when spoken to directly (tunes you out)	0	1	2	3
6. Runs about or climbs excessively in situations in which it is inappropriate	0	1	2	3
7. Does not follow through on instructions or fails to finish tasks (i.e. “go upstairs, get your shoes and socks”; has difficulty with transitions)	0	1	2	3
8. Has difficulty playing quietly (alone or in groups)	0	1	2	3
9. Has difficulty organizing tasks and activities (i.e. choosing an activity, getting materials, doing steps in order)	0	1	2	3
10. Is “on the go” or acts as if “driven by a motor”	0	1	2	3
11. Avoids tasks that require sustained mental effort (i.e. puzzles, learning ABC’s, writing name)	0	1	2	3
12. Talks excessively	0	1	2	3
13. Loses things necessary for tasks or activities (i.e. mittens, shoes, backpack)	0	1	2	3
14. Blurts out answers before questions have been completed	0	1	2	3
15. Is easily distracted	0	1	2	3
16. Has difficulty awaiting turn	0	1	2	3
17. Is forgetful in daily activities (i.e. forgets papers, forgets directions)	0	1	2	3
18. Interrupts or intrudes on others	0	1	2	3

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