New Patient Intake Form

Today's Date:

Child's Last Name: Child's First Name:

DOB: Age: Male / Female

Language(s): Current School:

Siblings (Name, Age):

Parent/Guardian Name:

Relationship to Child:

Address:

State: Zip: Email:

Cell Phone: Alternate Phone:

Occupation: Marital Status:

Second Parent Guardian Name:

Relationship to Child:

Address:

State: Zip: Email:

Cell Phone: Alternate Phone:

Occupation: Marital Status:

Child's Doctor: Phone:

Other health providers working with your child:

Child's Insurance Provider:

Member #: If Medicaid, Specify Branch:

Who referred you to Building Beyond Basics?

What are your child's strengths?

What are your child's weaknesses?

New Patient History Form

Child's Name: DOB:

Birth History

What hospital was your child born at?

Was your child born full term? Yes / No If no, at how many weeks?

Length and weight at birth? Inches lbs. Oz.

Any complication with pregnancy or birth for the mother?

Any injury with pregnancy or birth for your child?

Small for Gestational Age (SGA)? Yes / No Breech? Yes / No

Did your child require forceps or suction for delivery? Yes / No

Was your child delivered via Cesarean Section? Yes / No Emergency / Scheduled

After birth did your child require extra hospitalization? Yes / No

For how long? NICU? Yes / No

Just after birth did your child present as jaundice? Yes / No

Apgar score at 1 minute: Apgar score at 5 minutes:

Did your child receive any diagnosis before leaving the hospital from birth?

Infancy History

Was your child breastfed? Yes / No If so, for how long?

Did your child have difficulty learning how to “latch on” to the breast? Yes / No

Was there a strong suck during feeding? Yes / No

Did your child tire rapidly during feeding? Yes / No

Did your child frequently spit up after feeding? Yes / No How often?

What formula was/is used?

Was/Is the formula whey based? Yes / No Soy based? Yes / No

Rice based? Yes / No Other type of base? Yes / No

Did your child show any intolerance to formula? Yes / No

Type of intolerance:

Did your child show any intolerance to infant foods? Yes / No

Type of intolerance:

As an infant, would you describe your child as any of the following?

Cried often, fussy, irritable? Yes / No / Sometimes Comments:

Non-demanding? Yes / No / Sometimes Comments:

Alert? Yes / No / Sometimes Comments:

Quiet? Yes / No / Sometimes Comments:

Passive? Yes / No / Sometimes Comments:

Active? Yes / No / Sometimes Comments:

Enjoyed being held? Yes / No / Sometimes Comments:

Resisted being held? Yes / No / Sometimes Comments:

Floppy when held? Yes / No / Sometimes Comments:

Tense when held? Yes / No / Sometimes Comments:

Had good sleep patterns? Yes / No / Sometimes Comments:

Had irregular sleep patterns? Yes / No / Sometimes Comments:

Early Childhood History

Did your child have difficulty learning to take a bottle? Yes / No

Describe:

Did your child have difficulty manipulating an infant spoon/fork? Yes / No

Describe:

Did your child arch back and/or throw their head back when upset? Yes / No

Describe:

Did your child tend to be stiff in early childhood or infancy? Yes / No

Describe:

Did your child enjoy cuddling and soften into your body when held in early childhood or infancy? Yes / No

Describe:

Did your child prefer certain positions in early childhood or infancy? Yes / No

Describe:

Did your child dislike lying on their stomach in early childhood or infancy? Yes / No

Describe:

Did your child enjoy car rides in early childhood or infancy? Yes / No

Describe:

Did your child enjoy infant swings in infancy? Yes / No

Describe:

Did your child tend to be generally compliant in early childhood or infancy? Yes / No

Describe:

Did your child ever have little white bumps on their skin, especially on the backs of their arms, elbows, or knees, in early childhood or infancy? Yes / No

Describe:

Did your child crave certain foods in early childhood or infancy? Yes / No

Describe:

Did your child get chronic ear infections in early childhood or infancy? Yes / No

Describe:

Developmental Milestones

In the following developmental milestones, please give the age of your child and comment on anything unusual.

Lift head - Age: Comments:

Roll over - Age: Comments:

Sit alone - Age: Comments:

Crawl - Age: Comment:

Was the crawling phase brief? Yes / No

Did your child crawl on hands and knees? Yes / No

Crawl only backwards? Yes / No

“Commando / belly” crawl? Yes / No

Put weight through their arms and “bunny hop”? Yes / No

Scoot while sitting on their bottom? Yes / No

Use a walker or exer-saucer? Yes / No

Chew on solid food - Age: Comment:

Walk - Age: Comment:

Cruise - Age: Comment:

Run - Age: Comment:

Drink from a cup - Age: Comment:

Say words - Age: Comment:

Say sentences - Age: Comment:

Toilet-trained bladder - Age: Comment:

Toilet-trained bowels - Age: Comment:

Undress themselves - Age: Comment:

Dress themselves - Age: Comment:

Manage zippers, buttons, snaps - Age: Comment:

Tie shoes - Age: Comment:

Climb upstairs - Age: Comment:

Step downstairs - Age: Comment:

Climb out of crib - Age: Comment:

Feed themself - Age: Comment:

Developed a dominant hand - Age: Comment:

Right / Left

Medical History

Has your child had any of the following or been immunized for any of the following? Please provide dates.

Meningitis?	Diagnosis date:	Immunization date:
Measles?	Diagnosis date:	Immunization date:
Chicken Pox?	Diagnosis date:	Immunization date:
High Fevers?	Diagnosis date:	
Mumps?	Diagnosis date:	Immunization date:
Whooping cough?	Diagnosis date:	Immunization date:
Scarlet fever?	Diagnosis date:	Immunization date:
Convulsions?	Diagnosis date:	
Diabetes?	Diagnosis date:	
Lung difficulties?	Diagnosis date:	
Heart difficulties?	Diagnosis date:	
Seizures?	Diagnosis date:	How often:
Allergies?	Diagnosis date:	To what?
	Reaction?	
Excessive vomiting?	Diagnosis date:	
Tuberculosis?	Diagnosis date:	Immunization date:
Polio?	Diagnosis date:	

Does your child have a history of an irregular heartbeat (i.e. arrhythmia, murmur)? Yes / No

Any other diagnoses or major illnesses?

Any physical injuries?

Has your child ever been hospitalized? Yes / No Date:

Diagnosis:

Does your child currently have (or had in the past) any casts, braces, or splints?

Does your child have any assistive devices (i.e. glasses, prosthetics)?

Does your child frequently catch colds? Yes / No

Does your child have problems with their bowels (i.e. constipation, diarrhea, gas)? Yes / No

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Does your child have a vision problem? Yes / No

If so, what is the diagnosis?

Has your child had an eye evaluation? Yes / No Date:

Optometrist / Opthamologist:

Does your child have a hearing problem? Yes / No

If so, what is the diagnosis?

Has your child had a hearing evaluation? Yes / No Date:

Audiologist / ENT:

Has your child had tubes surgically placed in their ears? Yes / No Right / Left

Date: Are the tubes still in place? Yes / No

Has your child ever been evaluated by a physical therapist? Yes / No

Name: Date:

Has your child ever been evaluated by an occupational therapist? Yes / No

Name: Date:

Has your child ever been evaluated by a speech and language therapist? Yes / No

Name: Date:

Has your child ever been evaluated by a psychologist? Yes / No

Name: Date:

Has your child ever been evaluated by a neurologist? Yes / No

Name: Date:

Has your child ever been evaluated by a counselor? Yes / No

Name: Date:

Has your child ever been evaluated by any other professional? Yes / No

Name: Date:

Has your child ever been diagnosed as failed to thrive? Yes / No Date:

Please list all prescription medications, over the counter medications, vitamins, or supplements your child is currently taking.

Name: Dose: Reason:

Name: Dose: Reason:

Name: Dose: Reason:

Name: Dose: Reason:

Present

What is your child's dominant hand? Right / Left / Unknown

What are your child's favorite foods?

Do any foods elicit a gag response?

What are your child's favorite toys? What do they do with these toys?

How long does your child play with the toy?

Who does the child prefer to play with?

What activities does your child least enjoy?

What extracurriculars is your child involved with?

What activities do you see your child avoid?

_____

Would you describe your child currently as any of the following?

Mostly quiet? Yes / No / Sometimes Comment:

Overly active/restless? Yes / No / Sometimes Comment:

Easily car sick? Yes / No / Sometimes Comment:

Easily fatigued/tired? Yes / No / Sometimes Comment:

Talks constantly? Yes / No / Sometimes Comment:

Very impulsive? Yes / No / Sometimes Comment:

Resistant to change? Yes / No / Sometimes Comment:

Overreactive? Yes / No / Sometimes Comment:

Very stubborn? Yes / No / Sometimes Comment:

Fights frequently? Yes / No / Sometimes Comment:

Usually happy? Yes / No / Sometimes Comment:

Has frequent temper tantrums? Yes / No / Sometimes Comment:

Clumsy? Yes / No / Sometimes Comment:

Difficulty separating from primary caretaker? Yes / No / Sometimes Comment:

Has nervous habits or tics? Yes / No / Sometimes Comment:

Wets the bed? Yes / No / Sometimes Comment:

Walks on tip-toes when excited or anxious? Yes / No / Sometimes Comment:

Easily frustrated? Yes / No / Sometimes Comment:

Has unusual fears? Yes / No / Sometimes Comment:

Difficulty bonding with peers? Yes / No / Sometimes Comment:

Difficulty learning new motor tasks? Yes / No / Sometimes Comment:

Difficulty learning new academic tasks? Yes / No / Sometimes Comment:

Picky eater? Yes / No / Sometimes Comment:

Sensitive to touch/texture? Yes / No / Sometimes Comment:

Sensitive to smells? Yes / No / Sometimes Comment:

Sensitive to sounds? Yes / No / Sometimes Comment:

Sensitive to light? Yes / No / Sometimes Comment:

Sensitive to movement? Yes / No / Sometimes Comment:

Sensitive to taste? Yes / No / Sometimes Comment:

Sensitive to anything else? Yes / No / Sometimes Comment:

Are there any precautions the evaluating therapist should be aware of?

Have there been any recent large changes in the family or in the child's life?

What is your major concern, if any?

Are there any other details about your child you would like to share?