BRAINCHILD INSTITUTE
Building Better Brains

NEW PATIENT INTAKE FORM

CHILD'S NAME (last, first, middle initial)	BIRTH DATE	CURRENT DATE
	/ /	/ /

Address

Telephone (Home) ( ) - (Business) ( ) - (Cell) ( ) -

School Attending _____ Grade _____

Referred by: _____

Mother's name _____ Father's name _____

Primary Email _____ Primary Email _____

Marital status of parents Married ☐ Divorced ☐ Separated ☐ Other ☐

Child Lives with (Name) Relationship

Reason for visit and any questions you hope to have answered:

PERSONS LIVING IN HOME:

FULL NAME	RELATIONSHIP TO CHILD	AGE	OCCUPATION

Please feel free to give expanded details next to any boxes you check that apply. You can also elaborate these details at the end of this packet or on the back/extra paper. Details are very beneficial. Thank You!

MEDICAL HISTORY

A. PRENATAL HISTORY: Please check all that apply

Bedrest ☐ Preterm Labor ☐ Limited Fetal Movement ☐ Gestational Diabetes ☐

1. Was pregnancy normal, without complications OR please indicate any illnesses or accidents during pregnancy

B. DELIVERY METHOD: ☐ **Vaginal**

If Vaginal: Vacuum Extraction ☐ Forceps Assisted Delivery ☐

☐ **Caesarean**

If Caesarean: Emergency ☐ Scheduled ☐

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a. Length of pregnancy _____ Length of labor in hours _____ Mother's age at delivery _____

b. Position of baby at delivery: ☐ Head first ☐ Breech ☐ Feet first

c. Child's weight at birth _____ Child's length at birth _____

2. Drugs (prescribed or non-prescribed, such as vitamins, alcohol, tobacco) used during pregnancy

_____

_____

3. Did mother see a doctor regularly during pregnancy? Yes ☐ No ☐

4. Describe activities during pregnancy (work, exercise, restrictions)

_____

_____

5. Were there complications at birth? (If yes, explain) :

YES	NO		
☐	☐	Breathing problems	_____
☐	☐	Oxygen needed	_____
☐	☐	Heart problems	_____
☐	☐	Birth injuries	_____
☐	☐	Cord around neck	_____
☐	☐	Rh Incompatability	_____
☐	☐	Fetal Distress	_____
☐	☐	Ventilation Tube (in lungs)	_____
☐	☐	Other Problems	_____

6. Was the baby placed in a special nursery (i.e., intensive care) following birth? Yes ☐ No ☐

If yes, for how long? _____

NEWBORN HEALTH INFORMATION

Please check all that apply to your child as a newborn :

☐ Low Apgars ☐ Aspiration ☐ Poor Weight Gain ☐ Meconium

☐ Discolored or bruised ☐ Low Muscle tone ☐ High Muscle Tone ☐ Seizures or tremors

☐ Torticollis ☐ Severe Jaundice ☐ Hypertensive to sound or light (Circle) ☐ Required exchange transfusion

☐ In NICU (how long _____)

7. Has your child had any problems with feeding?

☐ Vomiting ☐ Colic ☐ Acid reflux If yes, explain _____

☐ Constipation ☐ Diarrhea ☐ Poor suck _____

☐ Allergies to formula or milk _____

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DEVELOPMENTAL HISTORY

Did your child meet all of the follwing developmental milestones?

1. Age at which your child: _____ Roll from belly to back _____ Sat alone _____ Crawled _____ Walked alone

2. Is your child completely potty-trained? Check all that apply: ☐ Day ☐ Night Age completed _____

3. Did your child experience any of the following:

YES	NO		YES	NO	
☐	☐	Brief Crawling Stage	☐	☐	Abnormal Crawling Pattern
☐	☐	Skipped Crawling Stage	☐	☐	"Toe Walker"

4. List any motor delays (specify areas/ages). please check all that apply:

Poor muscle tone: Hypertonic ☐ Hypotonic ☐ Description: _____
Upper body ☐ Lower body ☐ Both ☐
Clumsy ☐ Vision challenges (glasses) ☐

SPEECH/LANGUAGE

1. List language(s) spoken in home _____

2. Was your child a quiet (Little or no babbling) or vocal baby? Quiet ☐ Vocal ☐

3. Did your child meet all of the following speech milestones? Please indicate at what age or if not at all:

_____ Babbled (made word-like sounds) _____ Said first words _____ Used gestures (pointing or leading adult to what he/she wants)
_____ Put two words together _____ Spoke in simple sentences
_____ Spoke in longer sentences _____ Used questions

4. How does your child primarily communicate? ☐ Gestures ☐ Single words ☐ 2-3 words ☐ Sentences

5. Do you or others have trouble understanding your child's speech? ☐ Yes ☐ No If yes, explain:

_____
_____
_____

6. Does your child drool excessively? ☐ Yes ☐ No

7. Does your child follow simple directions (such as "get your shoes", "sit on the sofa")? ☐ Yes ☐ No

8. Check the number of words your child consistently uses: ☐ None ☐ 1-25 ☐ 26-50 ☐ 51+

9. Give some examples of words or phrases your child uses: _____
_____
_____
_____

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BEHAVIOR / SOCIAL DEVELOPMENT (Historically or presently - please indicate)

1. During the child's life, have there been any changes in the family situation (such as a change in parents' marital status, frequent moves, change in family composition, imprisonment, death, etc.)? ☐ Yes ☐ No If yes, explain:

_____

_____

2. How does your child get along with other children? (Describe)

_____

_____

_____

3. Describe any of the following behaviors exhibited by your child (Please check all that apply)

☐ Temper Tantrums ☐ Biting ☐ Antisocial ☐ Anxiety / Nervous
☐ Extraordinarily Fearful ☐ Cranky / Inconsolable ☐ Sensitive to noise ☐ Sensitive to smell
☐ Startles easily ☐ Falls / trip frequently ☐ Bites / chews nails, clothes, etc. ☐ Cannot sit still
☐ Poor listening attention / requires repeated requests ☐ Poor sleep pattern (awakes, light sleeper, etc.)
☐ Talks excessively ☐ Feels hurt easily ☐ Misinterprets what is said ☐ Says "what?" or "huh?" often
☐ Has selective hearing ☐ Turns up TV loudly ☐ Trouble hearing in noise ☐ High threshold for pain
☐ Specific Diagnosis (ADHD, Asperger's, Spectrum Disorder, Down's Syndrome) - Circle one ☐ Poor eye contact
☐ Wants to interact but trouble following what is going on ☐ Poor pragmatics (social communication skills)
☐ Other children avoid him/her ☐ Has repetitive behaviors (e.g. lining up, same action with toy) ☐ Does not play purposefully with toys
☐ Takes everything literally (does not get humor, sarcasm or hints) ☐ Has musical inclination (enjoys singing and instruments)
☐ Poor musical ability (no rhythm, cannot sing well) ☐ Is creative / imaginative ☐ Lacks creativity / imagination
☐ Recognizes own strengths and weaknesses ☐ Other: _____

4. Has your child been diagnosed with Autism Spectrum Disorder? ☐ Yes ☐ No
If yes, please indicate the level of severity and services required to date:

_____

5. How do you usually discipline your child?:

_____

6. Does your child attend a Preschool or Child Care Center? ☐ Yes ☐ No If yes, what center does your child attend?

_____ How often? _____

7. If your child attends or recently attended a child care center or preschool, answer the following:
A. Are there any "problem" behaviors which your child has shown in the preschool or child care center which are not shown at home?
If yes, describe: _____

B. Describe any "problems" your child has shown at home that are NOT being shown in the preschool or child care center:

_____

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GENERAL HEALTH INFORMATION

1. Has your child ever had any of the following (check all that apply) :

- ☐ Healthy, No Problems
- ☐ Allergies
- ☐ Bleeding Problems
- ☐ Chicken Pox
- ☐ Cranky /Inconsolable
- ☐ Diabetes
- ☐ Eye / Vision Problems
- ☐ Feeding Problems
- ☐ Food Sensitivities
- ☐ Pneumonia
- ☐ Headaches
- ☐ Head Injury / Trauma
- ☐ Hearing Problem / Loss
- ☐ Prolonged High Fever
- ☐ Measles
- ☐ Mumps
- ☐ Seizures (Convulsions)
- ☐ Sleeping Problems
- ☐ Snores
- ☐ Stomach Problems
- ☐ Sensistive Stomach
- ☐ Susceptible to Colds
- ☐ Frequent / Chronic Ear Infections

2. If you have checked any of the above conditions, explain:

3. Has your child ever been hospitalized? ☐ Yes ☐ No If yes, explain:

4. Has your child had any surgeries (i.e. tubes in ears and if yes, how many sets?) ☐ Yes ☐ No If yes, explain:

5. Had a serious accident / illness? ☐ Yes ☐ No If yes, explain:

6. Has your child seen a doctor within the last year? ☐ Yes ☐ No If yes, explain:

7. Is your child currently taking any medications? ☐ Yes ☐ No If yes, describe type and purpose:

8. Provide the name and address of the child's primary care doctor:

9. Do any relatives have history of physical, emotional, speech/language, or learning problems? ☐ Yes ☐ No If yes, explain:

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EDUCATIONAL / COMPREHENSION - (Please check off all that apply and elaborate details where applicable)

Trouble with: ☐ Reading ☐ Spelling ☐ Reading comprehension ☐ Math

Problems learning: ☐ Letters ☐ Numbers ☐ Phonics (letter sounds) ☐ Sight word vocabulary

☐ Loses place when reading; needs to track with finger under words

☐ Complains of trouble seeing ☐ Close up ☐ At a distance

☐ Spells phonetically but cannot remember the rules (e.g.) silent "e")

☐ Reads well but cannot remember what was read (content) ☐ Poor auditory memory ☐ Has trouble hearing the teacher

☐ Good math computation skills but trouble with word problems ☐ Problems copying information from the board

☐ Hears well but is easily distracted ☐ Trouble following directions with more than one step ☐ Repeated a grade

☐ Other: _____

_____

Please check any of the following services your child is receiving or has received. List any details including date of service and protocols where applicable.

1. Neurology Consult

_____

_____

2. Physical Therapy

_____

_____

3. Occupational Therapy

_____

_____

4. Speech / Language Therapy

_____

_____

5. Psychoeducational or Neuropsychological Evaluation

_____

_____

6. Tutoring (which subjects)

_____

_____

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FAMILY HISTORY

Please indicate any family history of the folowing: hearing loss / challenges, auditory problems, diagnosis of ADD / ADHD, Spectrum or other disorders, etc.

RESOURCE INFORMATION

List below any service providers (individuals or organizations) that have medical, developmental, or educational records about your child (include agencies, physicians, therapists, hospitals, schools, etc.) related to the services you are requesting

NAME OF PROVIDER **ADDRESS**

PARENT OBSERVATIONS (Use additional paper if needed and attach)

1. How do you view your child's development compared to other children the same age?

2. Describe three or four things about your child that you consider to be strengths (Things your child does well, personality traits, interests, etc.):

3. Is there any additional information that you feel is important in order for us to better understand your child?

SIGNATURE OF PERSON COMPLETING THE FORM DATE

PRINT NAME

RELATIONSHIP TO CHILD

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