Thank you for filling out these intake pages which give us a wide background about your child’s history. Please note that some questions may not apply depending on your child’s age. When you have finished these forms, you may fax them back to 310-996-8991 or scan and email them to assistant@dbpeds.com

|  |  |
| --- | --- |
| **Child’s Name**: | **Date**: |
| **Child’s DOB**: |
| **Pediatrician**: |

|  |
| --- |
| **What are your concerns about your child**: |
|  |
|  |
|  |
| **When did you first notice this**? |
|  |
| **What has been done in the past to help the problem(s)?**  |
|  |
|  |
| **Why are you seeking help now**? |
|  |
|  |
| **What have you been told about the problem(s**)? |
|  |
|  |
| **What do you hope to gain from this evaluation**? |
|  |
|  |
|  |
| **How do you feel your child can best be helped**? |
|  |
|  |
| **Who suggested this evaluation / referred you**? |
|  |
| **What are your child’s special qualities and strengths**? |
|  |
|  |
| **What things do you presently not understand about your child**? |
|  |
| **Prenatal History** |
| **Was the pregnancy planned**? |
| **When did you realize you were pregnant**? |
| **Pregnancy Interventions (Surrogacy, In Vitro Fertilization, Hormonal assistance, etc**.)? |
|  |
| **Please describe any problems/concerns during pregnancy (i.e. high BP, diabetes, fevers**) |
|  |
|  |
| **Explain all treatments/exposures during pregnancy. Please include when in pregnancy (early, middle, late, throughout) and the amount taken**:  |
|  |
|  |
| **Vitamins / Medications**: |
| **Cigarettes / Alcohol / Other drugs**: |
| **Any known prenatal tests and results**? (amniocentesis, ultrasounds) |
|  |
| **Any problems with other pregnancies? Miscarriages**? |
|  |
| **Birth History** |
| **Hospital**: |
| **Gestational Age in weeks (37-42 weeks is considered as full term**): |
| **Birth Weight**: | **Birth Length** (if known): |
| **Birth type** (circle): Vaginal / C-section / Vacuum Assisted / Natural |
| **If C-section, why**? |
| **Apgar scores**: Normal / Abnormal / Unknown |
| **Any concerns in the newborn period**? |
| **Did your child pass a newborn hearing screen**? Yes / No / Don’t know |
| **Did your child stay in the Newborn ICU**? Yes / No. If so, how long? |
| **If so, what issues did your child have in the Newborn ICU**: |
|  |
| **How did feedings go for your child as a newborn / infant**? |
|  |
| **How did sleeping go for your child as a newborn / infant**? |
|  |
| **Any other issues from the newborn period**? |
|  |

|  |
| --- |
| **Medical History** |
| **Please list any/all medical problems, concerns and diagnoses your child has had**: |
|  |
|  |
|  |
| **Other sub-specialists who care for your child**?  |
|  |
|  |
|  |
| **Hospitalizations**: |
|  |
|  |
| **Surgical history**: |
|  |
|  |
| **Has your child had any vision problems**?  |
|  **Any vision evaluations**? |
| **Has your child had any hearing problems**?  |
|  **Any hearing evaluations**? |
| **Has your child had any genetics evaluations**? Results |
|  |
|  |
| **Allergies to Medication**: |
| **Food Allergies**: |
|  |
| **Has your child received all scheduled immunizations**? Yes / No |
| **Current Medications (Name, dosage, approximate start date):** |
|  |
|  |
|  |
| **Past Ongoing Medications (Name, dose, approximate start and stop date, why stopped):** |
|  |
|  |

|  |
| --- |
| **Medical Problems: (Yes / No, Comment if yes)** |
| **Problems with vision? Crossed eyes? Wears glasses**?  |
| **Problems with hearing**? |
| **Serious or chronic health problem (such as diabetes**): |
| **Birth defect or birthmarks? Congenital heart disease**? |
| **Serious infections or illness (e.g. meningitis**)? |
| **Serious injury, burn or broken bones**? |
| **Head injury or lost consciousness**? |
| **Frequent accidents or multiple minor injuries**? |
| **Fainting spells or dizziness**? |
| **Seizures, convulsions or staring spells**? |
| **Motor tics (blinking, squinting, head tossing**)? |
| **Vocal tics (sniffing, grunting, throat clearing, noises)?** |
| **Obsessions / compulsive mannerisms (hand washing, picking, counting)?** |
| **Frequent headaches? Migraines**? |
| **Serious ear infections? Chronic antibiotics or ear tubes**? |
| **Serious nose, mouth or throat problems**? |
| **Thyroid disorders or other hormone problems**? |
| **Respiratory or lung problems (pneumonia, asthma)?** |
| **Too fast heart beat (palpitations) or chest pains**? |
| **Frequent stomachaches**? |
| **Problems with vomiting, diarrhea or constipation**? |
| **Problems with kidneys, bladder or urine**? |
| **Blood problems or anemia (iron deficiency or low blood count)?** |
| **Problems with skin / rashes**? |
| **Problems with allergies / congestion**? |
| **Poisoning or exposure to toxic chemicals (e.g. lead)?** |
| **Unusual reaction to immunization**? |
| **History or suspicion of tobacco, alcohol or drug use**? |
| **Problems with restless sleep or snoring**? |
| **Difficulties with eating, diet or appetite**? |
| **Small for age or very underweight**? |
| **Over-eats or overweight**? |
| **Changes in weight / appetite**? |
| **Changes in concentration / productivity / school performance**? |
| **Any herbal medicines/nutritional supplements**? |
| **Any non-medical treatments (diet, chiropractic, acupuncture**)? |
| **Abnormal sexual development**?  |
| **Medical Problems (continued): (Yes / No, Comment if yes)****Abnormal energy level? (low, too high**)? |
| **Abnormal thoughts? (hallucinations, mind playing tricks, racing thoughts)** |
| **Dangerous thoughts? (thoughts of hurting self or others)** |
| **Abnormal moods? (sad, guilty, too high, irritable, mood swings** |

|  |
| --- |
| **Family Composition** |
| **Child lives with (circle**): Birth Mother / Birth Father / Stepmother / Stepfather / Partner / Adoptive Mother / Adoptive Father / Foster Mother / Foster Father / Guardian / Other Adult (e.g. grandparent or boyfriend) Specify: |
|  |
| **Child’s siblings (name, gender, date-of-birth, full/half/adopted/step, live in/out of home) and other children in the home**: |
|  |
|  |
|  |
|  |
|  |
| **Parent #1’s Name (M/F)**: | **Age**: | **Occupation**: |
| **Highest level of school completed**: |
| **Typical alcohol consumption by mother (wine, beer, etc.):** |
| **Parent #2’s Name (M/F)**: | **Age**: | **Occupation**: |
| **Highest level of school completed**: |
| **Typical alcohol consumption by father (wine, beer, etc.):** |
| **Parents’ Marital Status**: Married / Never married / Separated / Divorced / Widowed |
| **What languages are spoken in the home**? |
| **What religions/ethnicities are represented in the family**? (details) |
|  |
| **How do parents get along with each other**? |
| **If separated/divorced, how long has it been**? |
| **Where does the child live**? |
| **Child Care arrangements (caregiver(s), location, hours, activities, other kids**): |
|  |
| **Contact with non-custodial parent or custody arrangements**: |
|  |
| **Family Composition (continued)****What does your child do after school**? |
|  |
| **Any special circumstances or stresses in the family situation**? |
| **What does the family enjoy doing together**? |
|  |
| **What does the child enjoy doing**? |
|  |
| **Is there TV / Internet in the child’s bedroom**?  |
|  |

|  |
| --- |
| **Diet History** |
| **Does your child have any special diet at this time**?  |
| **Does your child have any dietary restrictions**? |
| **Does your child have feeding problems currently**? (including chewing, swallowing, drooling) |
|  |
| **Has your child had feeding problems in the past**? |
|  |
| **Describe your child’s current drinking / eating of the following, including daily amount**: |
| - Milk (breast milk, formula, milk): |
| - Other liquids (water, juice, soda): |
| - Breads / Grains: |
| - Fruits / Vegetables: |
| - Meats / Proteins: |
| - Junk food / sweets: |
| Sample daily diet: |
| **Breakfast**: |
|  |
| **Lunch**: |
|  |
| **Snack**: |
| **Dinne**r: |
|  |
| **Dessert**: |
| **Have you made any changes to your child’s diet over time? What did you do and why**? |
|  |
| **Sleep History** |
| **When did your child first sleep through the night**? |
| **Does your child have any sleep problems currently**? (falling asleep, staying asleep, waking up early, snoring, restlessness): |
|  |
|  |
| **Has your child had sleep problems in the past**? |
|  |
| **Where does your child sleep**? |
| **Describe your bedtime routine**: |
|  |
| Sample daily sleep pattern: |
| - Naps: |
| - Time put to bed: |
| - Time until they fall asleep:  |
| - Time they wake up in morning: |
| **Activities** |
| **Describe outdoor play**: |
| **Describe indoor play**: |
| **How does your child get along with peers at school / structured activities**? |
|  |
| **How does your child get along with peers outside of schools**?  |
|  |
| **How often does your child have a one-on-one get-together with a peer each month**? |
|  |
| **What are your child’s favorite activities**? |
|  |
|  |
| **What activities does your child do well**? |
|  |
| **What activities present the greatest difficulty for your child**? |
|  |
| **Are there recent behavior problems your child has had that have been concerning**? Any history of  |
| aggression? (give examples) : |
|  |
|  |

|  |
| --- |
| **Developmental History** |
| **Have you had any developmental concerns about your child? Yes / No. If yes, explain**: |
|  |
|  |
| **If yes, at what age did these concerns develop**? |
| **How old was your child when they did the following (ok to state “don’t recall”, “not sure” or “not yet”):** |
| - Sat without help: | - Crawled: |
| - Walked: | - Pointed at object: |
| - Waved goodbye: | - Brought an item to show you: |
| - Said their first word(s): | - What word(s)?: |
| - Fed using a spoon: | - Drank from a cup: |
| - Potty trained: |
| - Indicated wants with words/gestures: |

|  |
| --- |
| **Speech and Verbal Understanding – Does your child…** |
| - Say single words? If so, how many single words **:** |
| - Uses signs to communicate? If so, how many signs |
| - Combine two words together (e.g. "Mama, Go"; "Give ball") |
| - Speaks in sentences of a few words in length? |
| - Tells stories, using long sentences? |

|  |
| --- |
| **Behavior:** |
| **- Points to pictures in a book with understanding**? (e.g. responds to "Where's the dog?") |
| - **Points to body parts**? (e.g. responds to "Where's your nose?") |
| - **Makes good eye contact when talking with you**? |
| - **Echoes words or phrases**? |
| - **Speaks in unusual tone or manner** |
| - **Hard to get child's attention** |
| - **Seems preoccupied, aloof or distant** |
| - **Repetitive behaviors** (flaps hands, moves body or fingers in unusual ways) |
| - **Prefers to be alone; ignores others** |
| - **Difficulty relating to peers or making friends** |
| - **Unusual play behaviors; little pretend play** |
| - **Has unusual or very intense interests** |
| - **Takes things too literally; misses the point** |
| - **Handles change poorly; insists on sameness** |
| **Temperament (rate from 1-7)** |
| **Activity Level (1 = low level of activity, 7 = very active, restless**): |
| **Self-Control (1 = patient, 7 = impulsive):** |
| **Concentration (1 = stays with task, 7 = easily distractible**): |
| **Intensity (1 = low-key, 7 = forceful):** |
| **Regularity (1 = predictable, 7 = erratic**): |
| **Persistence (1 = easily diverted, 7 = stubborn):** |
| **Sensory Threshold (1 = unbothered, 7 = sensitive):** |
| **Initial Response (1 = approaches easily, 7 = withdraws from new situation):** |
|

|  |
| --- |
| **Adaptability (1 = flexible, 7 = rigid):** |
| **Self-confidence (1 = arrogant, 7 = low self-esteem):** |

 |
| **Predominant Mood (1 = cheerful, 7 = gloomy):** |

|  |
| --- |
| **Daily Activities, How many hours a day does your child spend…** |
|  | Typical Weekday | Typical Weekend |
| Doing homework |  |  |
| Extracurricular activity (which?) |  |  |
| Exercising (which?) |  |  |
| Watching TV / Movies |  |  |
| Talking on the phone |  |  |
| Computer for work |  |  |
| Computer for leisure |  |  |
| Other major activities (list): |

|  |
| --- |
| **Does your child show any of the following anxious tendencies? Have they in the past? If so, have the issues been mild or significant?** |
| Trouble with separation?  |
| Worry in social situations about their performance? |
| Trouble speaking in social situations? |
| Worry about a lot of different things? |
| Repetitive thoughts those are hard for them to control? |
| Uncomfortable if they can’t do same thing over and over in a special order or manner? |
|  |
| Specific worry that makes them avoid specific situations? |
| Sudden panic reactions without a clear cause? |
| Traumatic experiences that have affected them? |

|  |
| --- |
| **School History** |
| Name of Current School: |
| School District: | School Type: Public / Private / Other: |
| Main Teacher(s): |
| Number of teachers in class: | Number of Aides: | Number of students: |
| Principal: |
| Current Grade or Level: | Length of time at this school (in yrs): |
| Type of class (e.g. Special Ed, Inclusion, Typical): |
| School phone: |
| Special accommodations (e.g. has a behavioral aide, special seating): |
| Does your child have an IEP? (Individualized Education Program): |
|  If so, do you know your child’s eligibility? |
|  |
|  What services do they receive? |
|  |
| Were any problems with academics or behavior reported? |
| If yes, please describe the teacher or parent concerns : |
|  |
|  |
| How does your child get along with other kids of the same age? |
|  |
|  |
| Name of close friends? What do they do together? How often? |
|  |
|  |

|  |
| --- |
| **Schools Attended** |
| School Name | Grades Attended | Academic/Learning Problems? Grades? | Behavioral Problems? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Intervention Services** (If applicable) |
| Has your child been referred to the Regional Center? When and by whom? |
|  |
| Name of Regional Center:  |
| Counselor: |
| Has your child been referred to the school district? |
| When and by whom? |
| Dates of Individualized Education Program (IEP) Meetings with the School District: |
|  |

|  |
| --- |
| **Therapies** |
| Therapy Type | Therapist/Agency | Start/End | Length of Sessions |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Did the therapies you listed above seem to help / were you satisfied with the services? |
|  |
|  |

|  |
| --- |
| **Biological Family Medical and Psychiatric History** |
| (if adopted indicate information on any known biological relatives and indicate information on adoptive family members on lines below) |
| **Anyone in the child’s biological family have:** | **Yes** | **No** | **Relation to Child / Explain specific issue** |
| Attention problems/ADHD |  |  |  |
| Behavior problems as child or teen |  |  |  |
| Speech or language problems |  |  |  |
| School problems |  |  |  |
| Motor development problems, late walking, hypotonia |  |  |  |
| Coordination / Fine Motor problems |  |  |  |
| Reading problems, dyslexia or other learning disability |  |  |  |
| Seizures or neurological problem |  |  |  |
| Issues with growth / stature |  |  |  |
| Unusual drug reaction |  |  |  |
| Intellectual Disability/Mental retardation |  |  |  |
| Birth defect or genetic disorder |  |  |  |
| Tics/Tourette’s Syndrome |  |  |  |
| Autistic spectrum disorder |  |  |  |
| Thyroid problems |  |  |  |
| Early heart problems (describe) |  |  |  |
| Physical or sexual abuse |  |  |  |
| Depression |  |  |  |
| Bipolar / manic depression |  |  |  |
| Social problems/shyness |  |  |  |
| Anxiety or panic attacks |  |  |  |
| Obsessive-compulsive disorder |  |  |  |
| Schizophrenia |  |  |  |
| Alcohol / Drug problems |  |  |  |
| Other relevant information not covered above (i.e. adoption history, other concerns): |
|  |

**PLEASE REMEMBER TO RETURN THIS FORM BEFORE YOU COME IN FOR YOUR FIRST APPOINTMENT BY FAX (310)996-8991 OR YOU MAY EMAIL IT TO** **ASSISTANT@DBPEDS.COM** **. IF NOT, THE FORM WILL HAVE TO BE COMPLETED IN OUR OFFICE BEFORE YOU SEE THE DOCTOR. THANK YOU.**