

# INFANT AND TODDLER DEVELOPMENT CLINIC PATIENT HISTORY AND INTAKE FORM

Today's Date: \_\_\_\_\_

<b>Child's Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Your Name</b> <i>(Last, First, M.I.):</i> Your relationship to the child:		
<b>What are your specific concerns about your child today?</b>		
<b>Email address:</b>	<b>Phone number:</b>	

**CURRENT HEALTH CONCERNS**

\_\_\_ **MY CHILD HAS NONE OF THE SYMPTOMS LISTED BELOW UNLESS CHECKED**

**PLACE A CHECKMARK NEXT TO ANY SYMPTOM OR CONDITION YOUR CHILD CURRENTLY HAS**

Weakness/fatigue	Hoarse voice	Blood in stool
Fever/chills	Trouble breathing	Difficulty gaining weight
Sleep difficulties	Wheezing	Poor eating/drinking
Seizures	Coughing	Easy bruising
Trouble seeing/eye problems	Heart murmur	Yellow skin/jaundice
Trouble hearing/ear problems	Vomiting	Rash/skin problems
Trouble swallowing/chewing	Diarrhea	
	Constipation	

**List your child's current medications, including over-the-counter medications, vitamins, supplements, inhalers, etc.**

Name of Medication	Strength	Frequency

**Is your child allergic to anything? (medicines, food, other)?**       No    Yes   If yes, please list:

**Are your child's immunizations up to date?**       No    Yes

**Is your child receiving any therapies? (physical, occupational, speech)**       No    Yes   If yes, please list:

**Is your child seeing any medical specialists besides the primary doctor:**

**If this is a follow up visit, please list any health or developmental issues or concerns that have occurred since last visit with us:**

**DEVELOPMENTAL SKILLS HISTORY**

Let us know what your child can do now below: **Does your child...**

<b>GROSS MOTOR</b>	<b>Yes/No</b>
Roll over	
Hold head up steadily	
Sit alone	
Crawl	
Walks along furniture	
Walks alone	
Runs	
Walks up/down steps with hand held or holding wall or railing	

<b>PROBLEM-SOLVING/FINE/VISUAL MOTOR</b>	<b>Yes/No</b>
Tracks objects with eyes in all directions	
Reaches for toys	
Transfers toys from hand to hand	
Looks for dropped toys out of sight	
Releases objects into your hand or a container	
Uses thumb and fingers to pick up a tiny objects	
Scribbles	
Stacks blocks	
Puts shapes into a simple puzzle	
Put nesting cups together in the correct order	

<b>SELF-HELP SKILLS</b>	<b>Yes/No</b>
Holds bottle or cup	
Finger feeds self	
Holds spoon or fork and feeds self	
Pushes arms through sleeves	
Removes simple clothing (i.e. socks, shoes)	
Imitates simple household chores (i.e. clean-up, sweeping)	

<b>SOCIAL-EMOTIONAL SKILLS</b>	<b>Yes/No</b>
Smiles socially	
Recognizes difference between parents and strangers (stranger anxiety)	
Developed separation anxiety from parent	

<b>LANGUAGE SKILLS</b>	<b>Yes/No</b>
Participates in vocal turn-taking or back and forth sound play	
Plays interactive social games such as peek-a-boo	
Brings things to show you	
Waves bye-bye	
Uses a reaching gesture to communicate a desire	
Uses a definite finger point to indicate a want or need	
Uses a definite finger point to show you something and looks back to see if you are looking	
Follows a verbal direction coupled with a gesture	
Follows a verbal direction WITHOUT a gesture	
Says mama or dada	

**DAILY ROUTINES**

Eating-

Breastfeeding or formula- how many times per day and/or how many ounces per day:

Baby food- how much and how many times per day:

Table food-

**Any coughing, choking or gagging with liquids or food?**

Sleeping-

Does your child sleep through the night?

How many naps if any during day?

Elimination

How many wet diapers on average per day?

How often does child have a bowel movement? Any concerns with constipation or diarrhea?

Child Care

Does your child attend child care?

**PLEASE COMPLETE IF YOU ARE A NEW PATIENT OR RETURNING PATIENT WITH CHANGES OTHERWISE STOP HERE**

**CHILD'S HEALTH HISTORY**

**Prenatal History**

Was there any difficulty getting pregnant or any fertility treatments?

Yes  No

- Please list the treatments used:

Number of prior pregnancies: \_\_\_\_\_

Mother's age during pregnancy: \_\_\_\_\_

Father's age during pregnancy: \_\_\_\_\_

When did prenatal care begin?:

- First Trimester
- Second Trimester
- Third Trimester
- No prenatal care

Length of pregnancy:

Were there any complications during pregnancy?

Mother's weight gain during pregnancy:  
 too little  just right  too much

Please list **ALL medications/supplements** taken during pregnancy:

Mother's health during pregnancy:

Good  Fair  Poor

Did mother drink alcohol or use drugs during pregnancy?

Yes  No

Did mother have any of the following problems during pregnancy (check):

- Vaginal bleeding or spotting
- Prenatal monitoring or test (amnio, stress test, ultrasound)
- Hospitalization
- Diabetes
- Fever, Rash, Infection (Rubella, CMV, HIV)
- Serious Injury or Surgery
- Seizures or convulsions
- Stresses or worries (Specify):

Other problems:

Baby's movements in utero were:

too little  just right  too much

**Labor/Delivery**

How long was labor?

Type of Delivery:

Vaginal  C-Section

Were there complications during labor or delivery?  Yes  No

If yes, what?:

- Premature rupture of membranes

Baby's position

- Head down (vertex)
- Legs or bottom down (breech)

Birth Weight \_\_\_\_\_

<input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Forceps/vacuum <input type="checkbox"/> Baby required oxygen or resuscitation <input type="checkbox"/> Failure to progress <input type="checkbox"/> Maternal fever <input type="checkbox"/> Other problems:	How long did your baby stay in the hospital after birth?  Did the baby spend time in the NICU? <input type="checkbox"/> Yes <input type="checkbox"/> No  Problems in the newborn period?  Did your baby pass a <u>newborn hearing test</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Has your child had any operations?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list date and reason below:
<b>Has your child ever been hospitalized?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:
<b>Does your child have any chronic medical conditions</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:

**FAMILY HEALTH HISTORY**

Does anyone in the family have any of the following conditions (check all that apply and indicate which family member):

Attention problems; hyperactivity ("ADHD")		Alcohol or drug abuse		Seizures	
Mental Retardation		Trouble with law; arrested; delinquency		Cerebral palsy	
Learning Disabilities		Autism, Asperger Syndrome		Birth defects, genetic syndromes	
Failure to graduate from high school		Physical or sexual abuse		Vision problems	
Mental Health problems (depression, anxiety)		Sudden death/early heart disease		Hearing problems	
Aggression, violence		Tics or Tourette Syndrome		NONE OF THE ABOVE	
Other:					

**SOCIAL HISTORY**

Who lives with your child at home?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Thank you for your time!  
 The Infant Toddler Development Clinic Team