**CEREBRAL PALSY PROGRAM INTAKE FORM**

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| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: ⁭ 🞐 Male ⁭ 🞐 Female |
| Parent/Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please list names of any other Medical Specialists that this child is currently seeing at Riley or elsewhere: |
| **1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Maternal Health and Birth History**

|  |  |
| --- | --- |
| **1.** Was the child? ⁭ 🞐 Premature ⁭ 🞐 Full -Term ⁭ 🞐 Late**2.** Length of Pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weeks |  |
| **3.** Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **4.** How many weeks was baby in the hospital after birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **5.** Location of Delivery: ⁭Hospital or Birth Center ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **6.** Delivery Method 🞐 Vaginal 🞐 C-Section 🞐 Breech 🞐 Forceps 🞐 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**7.** Did the mother have a difficult labor? 🞐Yes 🞐 No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **8.** Did the infant experience any of the following problems at birth? 🞐 Bruising 🞐 Jaundice 🞐 Difficulty feeding ⁭ 🞐 Stuck in birth canal 🞐 Cord around neck 🞐 Breathing Problems 🞐 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **9.** Mother’s Condition: # Pregnancies\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Live Births\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #Miscarriages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **10.** Mother’s Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11. Father’s Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **12.** Mother’s Health Conditions During Pregnancy (check all that apply): ⁭ 🞐 Hypertension ⁭ 🞐 Diabetes ⁭ 🞐 Toxemia  ⁭ 🞐 Vaginal Bleeding 🞐 Thyroid Problems 🞐 Premature Labor 🞐 Vomiting 🞐 Recurrent Infections 🞐 STD 🞐 HIV ⁭ 🞐 Cigarettes (# of packs per day: \_\_\_\_\_\_\_\_) 🞐 Alcohol (# of drinks per week: \_\_\_\_\_\_\_\_) 🞐 Drug Exposure 🞐 Preeclampsia ⁭ 🞐 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **13.** Stresses During Pregnancy (physical and/or emotional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **14.** Please list any medications taken by mother during the pregnancy: Prescription: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Over the Counter, Vitamins, or Nutritional Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Place Patient Label Here*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hosp#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This Section for Office Use Only*

**Cerebral Palsy Program**

**History of Present Illness**

Person Completing this Form:

Relationship to Patient: ⁭ 🞐 Mother ⁭ 🞐 Father ⁭ 🞐 Grandparent

⁭ 🞐 Foster Parent ⁭ 🞐 Legal Guardian ⁭ 🞐Other:

What are your main concerns today?

|  |
| --- |
| **Clinician Notes****For Office Use Only** |
| **HPI: EPF: 1 – 3, D: 4, C: 4+****Location, Quality, Severity, Duration, Timing, Context, Modifying facts, other signs & symptoms** |
| Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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|  |
| Kcal/kg/day: |
| CC/kg/day: |

Specific Concerns (check all that apply)?

 ⁭ 🞐 Behavior Issues 🞐 School

 ⁭ 🞐 Diet/Nutrition/Feeding 🞐Spasticity

 ⁭ 🞐 Growth 🞐 Refills/Medications

 ⁭ 🞐 Equipment 🞐 G-tube

Would you like to talk to a Social Worker today? ⁭ 🞐 Yes ⁭ 🞐No

**Diet & Nutrition**

**1.** How does your child feed? ⁭ 🞐 By Mouth ⁭ 🞐 G-tube ⁭ 🞐 GJ

**2.** Name of Formula/Milk \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** How often does your child feed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** How much formula/milk at each feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.** Does your child drink anything else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6.** What solids does your child eat? ⁭ 🞐 Purees ⁭ 🞐 Table foods

**7.** Does your child? ⁭ 🞐 Choke/Gag 🞐 Cough 🞐 Refuse Feedings

**8.** Does your child spit up or vomit? 🞐 Almost Never 🞐 Often 🞐 Every Meal

**Mobility**

1. Is your child mobile?

⁭ 🞐Yes ⁭ 🞐 No

1. If so, how does he/she get around?

⁭ 🞐 Crawl ⁭ 🞐 Cruise ⁭ 🞐 Roll ⁭ 🞐 Assistive Device

⁭ 🞐 Walker ⁭ 🞐 Manual Wheelchair ⁭ 🞐 Power Wheelchair

**Language**

1. How does your child let you know what he/she wants?

 ⁭ 🞐Eye Gaze ⁭ 🞐Words ⁭ 🞐 Facial Expressions

⁭ 🞐Crying ⁭ 🞐Pointing ⁭ 🞐Assistive Device

**Services**

1. Is your child currently receiving any of the following services?

|  |  |
| --- | --- |
| ⁭ 🞐 Occupational Therapy  | ⁭ 🞐 Physical Therapy  |
| ⁭ 🞐 Speech Therapy | ⁭ 🞐 Behavioral counseling |

1. Is your child presently in any type of school? ⁭ 🞐 Yes ⁭ 🞐No

Classroom Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Name:

Grade:

Hours per Day: Days per Week:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visit Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Place Patient Label Here*

**EQUIPMENT**

**Home Care Agency**

Name

⁭ 🞐 Nursing ⁭ 🞐 Supplies

|  |
| --- |
| **Clinician Notes****For Office Use Only**  |
|  |
|  |
|  |
|  |
| ⁭ 🞐 Influenza |

**Medications – Please complete medication sheet**

**ALLERGIES**

Does your child have any drug allergies? ⁭ 🞐 Yes ⁭ 🞐 No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your child’s immunizations up to date? ⁭ 🞐 Yes ⁭ 🞐 No ⁭ 🞐 Unsure

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hosp#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visit Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This Section for Office Use Only*

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**Review of Systems**

**Please review each item as it relates to your child’s health.**

|  |  |  |
| --- | --- | --- |
| ***Constitutional*** ⁭ 🞐 Negative |  | ***Gastrointestinal*** ⁭ 🞐 Negative |
| ⁭ 🞐 Problems sleeping |  | ⁭ 🞐 Vomiting |
| ⁭ 🞐 Anemia |  | ⁭ 🞐 Diarrhea, or constipation |
| ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Neurological*** ⁭ 🞐 Negative |  | ***Urinary and Bladder System*** ⁭ 🞐 Negative |
| ⁭ 🞐 Seizures or staring spells |  | ⁭ 🞐 History of bladder or kidney infections |
| ⁭ 🞐 Balance problems |  | ***Musculoskeletal*** ⁭ 🞐 Negative |
| ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | ⁭ 🞐 Muscle weakness |
| ***Eyes*** ⁭ 🞐 Negative |  | ⁭ 🞐 Tightness or stiffness in joints |
| ⁭ 🞐 Vision loss or concerns |  | ⁭ 🞐 Receives Botox |
| ⁭ 🞐 Eyes crossing or lazy eye |  | ⁭ 🞐 ITB |
| Has your child had a vision test? ⁭ 🞐 No ⁭ 🞐 Yes If Yes, when? \_\_\_\_\_\_\_\_\_ |  | ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Skin*** ⁭ 🞐 Negative |
| ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | ⁭ 🞐 Eczema or rash |
| ***Ears/Nose/Throat*** ⁭ 🞐 Negative |  | ⁭ 🞐 G tube site or NG tube irritation |
| ⁭ 🞐 Hearing loss or concerns |  | ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ⁭ 🞐 Earache or discharge |  | ***Endocrine*** ⁭ 🞐 Negative |
| Has your child had a hearing test? ⁭ 🞐 No ⁭ 🞐 Yes If Yes, when? \_\_\_\_\_\_\_\_ |  | ⁭ 🞐 Thyroid problems⁭ 🞐 Pubertal changes |
| Does your child see a dentist? |  | ⁭ 🞐 Menses ⁭ 🞐No ⁭ 🞐 Yes If Yes, 1st period \_\_\_\_\_\_\_\_\_ |
| ⁭ 🞐 No ⁭ 🞐 Yes If Yes, when? \_\_\_\_\_\_\_\_ |  | ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Respiratory*** ⁭ 🞐 Negative |  | ***Safety/Other*** ⁭ 🞐 Negative  How does your child travel in a car? |
| ⁭ 🞐 Wheezing  |  |  ⁭ 🞐 Forward Facing Car Seat ⁭ 🞐 Booster Seat  |
| ⁭ 🞐 Snoring or noisy breathing with sleep |  |  ⁭ 🞐 Seat Belt ⁭ 🞐Tethered wheelchair |
| ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Are there any smokers living in your home? |
| ⁭ 🞐 Pulmonologist |  |  ⁭ 🞐 Yes ⁭ 🞐 No  |
| ***Cardiovascula*r** ⁭ 🞐 Negative |  | Do you have concerns about safety in your home?  |
| ⁭ 🞐 Heart problems |  |  ⁭ 🞐 Yes ⁭ 🞐 No  |
| ⁭ 🞐 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |   |
|  |  |   |
| ⁭ 🞐 **ALL OTHERS NEGATIVE** |  |   |

 Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Cerebral Palsy Program**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Past Medical, Family, Social History**

**First Visit –** Please fill out completely

**Repeat Visit –** Indicate ONLY changes since your last visit

|  |
| --- |
| ***Past Medical History*** 🞐 **No Changes Since Last Visit dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ***Please check all that apply******Illnesses****:* | ***Past Surgeries:*** |
| ⁭ 🞐 Seizure Disorder | ⁭ 🞐 Ear PE Tubes | ⁭ 🞐 G Tube |
| ⁭ 🞐 Asthma  | ⁭ 🞐 Tonsils Removed | ⁭ 🞐 Nissen |
| ⁭ 🞐 Pneumonia  | ⁭ 🞐 Adenoids Removed | ⁭ 🞐 VP Shunt |
| ⁭ 🞐 Other Illnesses/Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⁭ 🞐 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Injuries/Fractures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Procedures and Tests (such as MRI, chromosomes): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***Social History*** 🞐 **No changes Since Last Visit dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Patients Parents are: ⁭ 🞐 Married ⁭ 🞐 Divorced ⁭ 🞐 Separated ⁭ 🞐 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child Lives With: ⁭ 🞐 Both Parents ⁭ 🞐 Mother ⁭ 🞐 Father ⁭ 🞐 Foster Parents ⁭ 🞐 Other # of others living in home: \_\_\_\_\_\_\_\_\_ |
| # Of Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ages and health of Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother Employed? ⁭ 🞐 Yes ⁭ 🞐 No If yes, Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Father Employed? ⁭ 🞐 Yes ⁭ 🞐 No If yes, Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is the family currently receiving any of the following services? 🞐 WIC 🞐 SSI 🞐 CSHSC 🞐 Medicaid Waiver 🞐 Medicaid DisabilityChildcare Provided by: ⁭ 🞐 Parents ⁭ 🞐 Relatives ⁭ 🞐 Home Daycare ⁭ 🞐 Babysitter/Nanny ⁭ 🞐 Daycare Center |
| ***Family Medical History*** 🞐 **No Changes Since Last Visit dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Please indicate any history of the following illnesses among the patient’s immediate family by checking the appropriate box. Immediate family consists of parents, siblings, and grandparents only. |
| ⁭ 🞐 ADD/ADHD | ⁭ 🞐 Diabetes | ⁭ 🞐 Kidney Disease | ⁭ 🞐 Cerebral Palsy |
| ⁭ 🞐 Alcohol/Drug Abuse | ⁭ 🞐 Genetic Conditions | ⁭ 🞐 Learning Problems | ⁭ 🞐 Seizures/Epilepsy |
| ⁭ 🞐 Allergies/Asthma | ⁭ 🞐 Growth Problems | ⁭ 🞐 Liver Disease | ⁭ 🞐 Mental Retardation |
| ⁭ 🞐 Autism/Asperger/PDD | ⁭ 🞐 Heart Disease | ⁭ 🞐 Mental Illness | ⁭ 🞐 Neurological Disorder |
| ⁭ 🞐 Cancer | ⁭ 🞐 High Blood Pressure | ⁭ 🞐 Thyroid Problems |  |
|  |  |  |  |
| Other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 **Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**