Carolina Center *for* Restorative Medicine
Restoring Hope and Health with Heart

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Pediatric Intake Questionnaire

General Information

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home:_____ Cell: _____ Work: _____

Genetic Background: ◯ African American ◯ Hispanic ◯ Asian ◯ Mediterranean ◯ Native American ◯ Caucasian ◯ Northern European ◯ Other:

When, where and from whom did you last receive medical or health care? _____

_____

How did you hear about our practice? ◯ Clinical Website ◯ Other website ◯ Referral from doctor ◯ Referral from family/friend member ◯ Social Media ◯ Other: _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority, describe problem severity Mild, Moderate, Severe) and prior treatment/approach success (Excellent, Good, Fair).

Describe Problem	Severity			Prior Treatment/Approach	Success		
	mild	moderate	severe		Excellent	Good	Fair
Example: Post Nasal Drip	X			Elimination Diet	X		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Child's Birth History

Is the child adopted? ____ No ____ Yes If yes, at age ___ months/years and is from (country) _____

Pregnancy, Labor and Delivery History	Yes	No	Comments
1. Age of mother when child was born _____ years			
2. Is the child a twin or triplet?			
3. Any problems with other pregnancies? Miscarriages?			
4. Use in vitro fertilization or other method of conception?			
5. Were there any problems during the pregnancy?			
6. Any medications prescribed? Why?			
7. Gestational diabetes (sugar in urine)			
8. Any problem with blood pressure or toxemia?			
9. Any problems with infections (including herpes)?			
10. Smoking during pregnancy? If yes, how many packs per day? _____			
11. Drank alcohol (beer, wine, etc.) during pregnancy?			
12. Any street drugs (marijuana, cocaine, etc.)?			
13. Any problems during labor or delivery?			
14. Cesarean delivery? Why?			
15. Baby was born at _____ weeks			

Newborn History	Yes	No	Comments
1. Birth weight? _____ lbs. _____ oz.			
2. Were there any problems at birth or as a newborn?			
3. Were any birth defects or birth injuries noted?			
4. Put in Special Care or Intensive Care Nursery? If yes, for _____ days			
5. Have jaundice or need phototherapy?			
6. Very jittery or lethargic as a newborn?			
7. Baby had to stay extra days in the hospital?			

Infant Temperment

Please describe your child as an infant or toddler: _____

_____

More Infant Temperament	Yes	No	Comment
1. Problems with feeding in infancy?			
2. Severe or prolonged colic or excessive crying?			
3. Difficult temperament (irritable or demanding)?			
4. Excessively wiggly or active?			
5. Easily over-stimulated?			
6. Passive, shy or withdrawn?			
7. Didn't like to be held or cuddled?			
8. Trouble keeping a babysitter?			

The following questions are about your child's communication skills. Please answer if/when your child could . . .	Not yet	Yes	At What Age?
1. Understand and respond to his/her name?			
2. Understand simple commands?			
3. String sounds together (uh oh, gaga, bada, dada, mama)?			
4. Pretend to talk with inflections that sound like conversation?			
5. Say first word (that he/she used consistently)?			
6. Put two words together (want cookie, Mommy work, Dad car)?			
7. Use pronouns to refer to self and others?			
8. Strangers understand most of what he/she says?			
9. Attend to a short story and answers simple questions about it?			
10. Speak in fairly complex sentences.			

The following questions are about your child's motor skills. Please answer if/when your child could . . .	Not yet	Yes	At what Age?
1. Sit up without being held or propped?			
2. Crawl or scoot?			

The following questions are about your child's motor skills. Please answer if/when your child could . . .	Not yet	Yes	At what Age?
3. Walk alone?			
4. Jump off the floor with both feet?			
5. Throw a ball?			
6. Catch a medium-sized ball?			
7. Pick up small objects with thumb and one finger?			
8. Unwrap loosely wrapped small objects?			
9. String half-inch sized beads on a string?			
10. Copy letters?			

The following questions are about your child's self-help skills. Please answer if/when your child could . . .	Not yet	Yes	At What Age?
1. Feed self using spoon in scooping motion?			
2. Feed self using fork to pick up food?			
3. Help you in dressing/undressing him/herself?			
4. Unzip a zipper?			
5. Unbutton front buttons?			
6. Toilet-trained during the day?			
7. Toilet-trained at night?			
8. Wash/dry hands by him/herself?			

The following questions are about your child's pre-academic skills. Please answer if/when your child could . . .	Not yet	Yes	At What Age?
1. Identify basic colors consistently?			
2. Identify shapes consistently?			
3. Identify several letters consistently?			
4. Count 2-3 objects correctly?			
5. Can state the use of objects (e.g. car, fork)?			

Child's Behavioral HIstory

1. How do you handle misbehavior? _____

_____

_____

2. How does your child respond to being told "no" or being corrected for misbehaving? _____

_____

_____

3. How does your child respond to praise, rewards or positive reinforcement? _____

_____

_____

4. Do you and your partner agree on how to handle misbehaving?

◯ Usually Agree ◯ Sometimes Agree ◯ Sometimes Disagree ◯ Often Disagree

Please answer how often the items in each section below describe your child's behavior.

The following questions are about your child's sensory experiences.	**Never**	**Sometimes**	**Often**	**Very Often**	**Office Notes**
1. Usually sensitive hearing or sense of smell					
2. Bothered by how tings feel (clothes, begin hugged					
3. Over or under sensitive to pain					
4. Easily over-stimulated; winds up or shuts down					
5. Unusual or limited diet					
6. Hurts herself/himself on purpose					
7. Eats things that are not food ("pica")					
8. Unaware of dangerous situations					

The following questions are about repetitive behaviors or habits.	**Never**	**Sometimes**	**Often**	**Very Often**	**Office Notes**
1. Echoes words or phrases					
2. Hard to get child's attention					
3. Prefers to be alone; ignores others					
4. Does things just to get you to laugh					
5. Handles change poorly; insists on same routines					
6. Excessive or public masturbation					
7. Excessive thumb-sucking or nail-biting					
8. Other habits (e.g., pulls out hair or lashes)					

The following questions are about your child's ability to handle anxiety.	Never	Sometimes	Often	Very Often	Office Notes
1. Is fearful, anxious or worried					
2. Doesn't try new things for fear of making mistakes					
3. Is sad, unhappy or depressed					
4. Has unusual hard time being away from parents					
5. Refuses to speak except to family members					
6. Resists going to school					

The following questions are about your child's ability to follow rules and routines.	Never	Sometimes	Often	Very Often	Office Notes
1. Has temper tantrums					
2. Argues with adults					
3. Defies or refuses to do as asked					
4. Deliberately annoys others					
5. Is angry or resentful					
6. Tries to get even or takes out anger on others					
7. Blames others for misbehavior					
8. Bullies, threatens or intimidates others					
9. Does serious lying or cheating					
10. Starts physical fights					
11. Is cruel to animals					

Please review the following items and indicate if they describe your child's behavior.	Yes	No	Office Notes
1. Does your child enjoy being swung, bounced on you knee, etc.?			
2. Does your child take an interest in other children?			
3. Does your child like climbing on things such as the stairs?			
4. Does your child enjoy playing peek-a-boo/hide-and-seek?			

Please review the following items and indicate if they describe your child's behavior.	Yes	No	Office Notes
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?			
6. Does your child ever use his/her index finger to point, or to ask for something?			
7. Does your child ever use his/her index finger to point, to indicate interest in something?			
8. Can your child play properly with a small toy (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?			
9. Does your child ever bring objects over to you (parent) to show you something?			
10. Does your child look you in the eye for more than a second or two?			
11. Does your child ever seem oversensitive to noise (e.g. plugging ears)?			
12. Does your child smile in response to your face or your smile?			
13. Does your child imitate you? (e.g. you make a face-will your child imitate it)?			
14. Does your child respond to his/her name when you call?			
15. If you point at a toy across the room, does your child look at it?			
16. Does your child walk?			
17. Does your child look at things that you are looking at?			
18. Does your child make unusual finger movements near his/her face?			
19. Does your child try to attract attention to his/her own activity?			
20. Have you ever wondered if your child is deaf?			

Please review the following items and indicate if they describe your child's behavior.	Yes	No	Office Notes
21. Does your child understand what people say?			
22. Does your child sometimes stare at nothing or wander with no purpose?			
23. Does your child look at your face to check your reaction when faced with something unfamiliar?			

Child's Home Life

Stressful Life Experiences	Yes	No	Office Notes
1. Child had a very upsetting experience (e.g. witnessed violence, physical abuse, sexual abuse, severe accident)?			
2. Moved? Number of moves _____			
3. Out of home placement (foster care, residential center)?			
4. Family problems that may be bothering child?			
5. Divorce/separations/remarriage?			
6. Frequent arguments and/or physical abuse in home?			
7. Serious physical illness in parent, caregiver or sibling?			
8. Serious money or housing problems?			
9. Concerns about safety in neighborhood?			
10. Are there guns in the house?			

How much time per day does your child watch TV? _____

How much time per day does your child usually spend on computer/video games? _____

Child's Services History

Placement, Programs and Services (now or in the past)	# Days/ Week	# Min./Session	Comments
Early Intervention Program (0-3 years)? Name: _____			
Developmental specialist: _____			
Speech/Language Therapy?			
Occupational Therapy?			
Physical Therapy?			
Play Group?			
Behavior Therapy (also know as ABA or Floortime)?			
Provider: _____			
Day Care: Name: _____			
Pre-school: Name: _____			
School District: _____			
Teacher: _____ Phone: _____			
# of teachers/aids: _____ # of students: _____			
Does your child have his/her own 1:1 aide? _____			

Ever suspended from school or daycare? ◯ Yes ◯ No

Ever received any other special education or therapeutic services? ◯ Yes ◯ No If yes, specify: _____

_____

How satisfied are you with your child's current school placement and services?

◯ Very Satisfied ◯ Somewhat Satisfied ◯ Not Satisfied

Comments: _____

_____

_____

Medical History (check if applicable and comment if necessary)

Eyes

- ◯ Crosses or wandering eyes
- ◯ Vision problems
- ◯ Eye irritation
- ◯ Wears glasses

Skin

- ◯ Eczema
- ◯ Psoriasis
- ◯ Dry skin or other rash
- ◯ Yellow or crusty nails
- ◯ Slow healing bruises

Medical History (continued) (check if applicable and comment if necessary)

Ears, Nose, Mouth, Throat

- ◯ Frequent ear infections
- ◯ Hearing problems
- ◯ Difficulty talking
- ◯ Stuttering
- ◯ Thrush
- ◯ Sores in mouth/gums
- ◯ Frequent colds and sore throat
- ◯ Post nasal drip
- ◯ Throat clearing
- ◯ Nose bleeds
- ◯ Stuffy nose
- ◯ Tonsil infections
- ◯ Breathes thru mouth
- ◯ Dark circles under eyes
- ◯ Bad Breath
- ◯ Itchy throat
- ◯ Seasonal allergies

Cardiovascular

- ◯ Shortness of breath
- ◯ Needs to squat when playing

Respiratory

- ◯ Chronic or frequent cough
- ◯ Asthma or wheezing
- ◯ Shortness of breath
- ◯ Bronchitis
- ◯ Pneumonia

Genitourinary

- ◯ Urination problems
- ◯ Painful, burning urination
- ◯ Blood in urine
- ◯ Unusual odor in urine

Skin (continued)

- ◯ Crust behind the ears
- ◯ Cradle Cap or scaly scalp

Neurological

- ◯ Dizzy or fainting
- ◯ Periods of confusion
- ◯ Seizures/convulsions
- ◯ Tics or tremors
- ◯ Headaches

Gastrointestinal

- ◯ History of worms
- ◯ Loss of appetite
- ◯ Constipation
- ◯ Use of laxatives
- ◯ Abdominal bloating
- ◯ Noisy digestion
- ◯ Excessive burping or belching
- ◯ More than 3 BMs per day
- ◯ Loose bowels or diarrhea
- ◯ Nausea or vomiting
- ◯ Painful bowel movements
- ◯ Rectal bleeding
- ◯ Blood in stool
- ◯ Abdominal pain or cramping
- ◯ Excess gas

Psychosocial

- ◯ Nightmares
- ◯ Trouble falling/staying asleep
- ◯ Irritable
- ◯ Tantrums
- ◯ Spinning/flapping
- ◯ Usually disobedient

Genitourinary (continued)

- ◯ Persistent diaper rash
- ◯ Bedwetting problems
- ◯ Discharge from vagina or penis
- ◯ Itching or vaginal/penile area
- ◯ Redness around rectum
- ◯ Patient is potty trained

Musculoskeletal

- ◯ Painful or swollen joints
- ◯ Frequent complaints of aches or pains
- ◯ Posture problems
- ◯ Muscle coordination problems
- ◯ Strength problems

Endocrine

- ◯ Hormone problem
- ◯ Diabetes
- ◯ Excessive thirst or urination
- ◯ Heat or cold intolerance
- ◯ Hair loss
- ◯ Recent weight loss/gain

Hematologic

- ◯ Slow to heal after cuts
- ◯ Excessive bleeding
- ◯ Anemia
- ◯ Bruising tendency

Immunological

- ◯ Child is immunized
- ◯ Fevers
- ◯ Fatigue

Psychosocial (continued)

- ◯ Problems at school with friends
- ◯ Suicide attempts
- ◯ Extreme mood swings
- ◯ Sensitivity to odors
- ◯ Sensitivity to fabrics
- ◯ Sensitivity to smells
- ◯ Sensitivity to noises
- ◯ Aggression towards self
- ◯ Aggression towards to others
- ◯ Overly affectionate/not affectionate
- ◯ Difficulty organizing tasks
- ◯ Easily distracted
- ◯ Poor focus
- ◯ Poor listening skills
- ◯ Doesn't stay on task
- ◯ Easily forgetful
- ◯ Overly talkative
- ◯ Finger/foot tapping or leg restlessness
- ◯ Engages in physically daring activities
- ◯ Always on the go
- ◯ Impulsive
- ◯ Bothers or is annoying to others
- ◯ Interrupts others
- ◯ Impatient
- ◯ Unpredictable behavior
- ◯ Hot and explosive temper

Allergic Reactions/Sensitivities

Please indicate any allergies or sensitivities our child has to any of the following substances.

◯ Aspirin	◯ Latex	◯ Pollen	◯ Dustmite	◯ Penicillin
◯ Cephalosporins	◯ Mold	◯ Shellfish	◯ Eggs	◯ Pet dander
◯ Dairy products	◯ Peanuts	◯ Sulfa drugs	◯ Wheat	◯ Other: _____

Surgical History

Please list any surgeries your child has undergone and any complications involved.

Surgery	Year	Complications, if any

Family History

Check family members that have had any of the following

Condition	Mother	Father	Sister(s)	Brother(s)	Child	Child	Child	Child	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer													
Heart disease													
Hypertension													
Obesity													
Diabetes													
Stroke													
Autoimmune disease													
Arthritis													
Kidney disease													
Thyroid problems													
Seizure/epilepsy													
Psychiatric disorders													
Anxiety													
Depression													
Asthma													
Allergies													
Eczema													

Condition (continued)	Mother	Father	Sister(s)	Brother(s)	Child	Child	Child	Child	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Other
ADHD													
Autism													
Irritable bowel syndrome													
Dementia													
Substance abuse													
Genetic disorder													
Other:													
Other:													
Other:													