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Behavioral Health Consult Intake

Pediatrics at Newton Wellesley, P.C.
Boston Children's
Primary Care Alliance

pedinw.org
617-969-8989 | *fax* 617-928-0178

Today's date: _____

Patient's primary care provider (PCP): _____

Patient's name: _____

Date of birth: _____

Please indicate if patient is: ❍ Adopted ❍ Foster child

Person completing this form: _____

Relationship to patient: _____

Please complete the following questions to the best of your ability.

What is your primary concern about your child?

_____

_____

_____

_____

_____

When did you first become concerned about your child's development, behavior or mental health?

_____

_____

_____

What are your expectations for this visit? Are there any specific questions/concerns to be answered by this visit?

_____

_____

_____

Does your child have any previous diagnosis (i.e. ADHD, speech delay, etc.)? Please provide age at diagnosis and name of specialty provider.

_____

_____

_____

_____

Patient medical history and review of symptoms

List your child's **current** prescribed medications, vitamins and supplements. If prescribed by someone outside of Pediatrics at Newton Wellesley, please note prescriber.

_____

_____

_____

_____

List any **previous** long-term medications prescribed to your child and reasons for discontinuation:

_____

_____

_____

_____

Drug allergies: _____

_____

Food allergies: _____

_____

Birth history:

❑ Full term ❑ Complications during or after pregnancy ❑ NICU stay

Please describe: _____

_____

Hospitalizations:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Surgical procedures:

_____ Date: _____

_____ Date: _____

_____ Date: _____

NEXT PAGE >

Describe any of the following conditions/issues that your child has currently or has previously experienced and when they occured.

❑ Seizures/Convulsions

_____ Age: ___

❑ Headaches/Migraines

_____ Age: ___

❑ Dizziness/Syncope

_____ Age: ___

❑ Accidents/Head trauma/Concussion

_____ Age: ___

❑ Congenital heart disease

_____ Age: ___

❑ Other cardiac conditions

_____ Age: ___

❑ Hearing/Vision problems

_____ Age: ___

❑ GI issues (constipation, diarrhea, vomiting, reflux)

_____ Age: ___

❑ Sleep disturbance

_____ Age: ___

General

Diet: ❍ Regular ❍ Other/Concerns/Dietary restrictions

Please describe: _____

Does your child fatigue easily? ❍ No ❍ Yes

Describe your child's energy level.

_____

Describe your child's exercise level.

_____

Describe your child's sleep habits and bedtime routines. Does your child fall asleep easily? Sleep through the night? Sleep alone?

_____

_____

_____

_____

_____

Development

Please indicate any concerns you have specifically regarding your child's development: motor skills, language and speech, or behavior. When did you first become concerned?

_____

_____

_____

Please list any therapies (speech, OT, PT, ABA, social skills programming) your child previously received through Early Intervention, privately, or through your school district before entering kindergarten. (ex: speech through Early Intervention, once weekly x 1 year beginning at 9 months old)

Therapy	**Age**	**Duration**
Ex: Speech through Early Intervention	9 mo.	1 year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Academics

Current school: _____ Grade: _____

Has your child ever had a formal evaluation through school/your town or a private neuropsychological evaluation? ❍ No ❍ Yes

If yes, please provide a copy of the most recent evaluation and indicate:

Person or district who performed the evaluation:

_____ Date: _____

Date of last IEP or 504: _____

List current services patient **receives through school**:

_____

_____

_____

_____

List current additional services/therapies your child **receives outside of school**:

_____

_____

_____

_____

NEXT PAGE >

Social

List your child's favorite activities. What does he/she do with free time?

_____

_____

_____

Describe your child's interest in and interaction with peers/friends.

_____

_____

_____

Who generally disciplines your child? What methods are used?

_____

_____

Sensory

Indicate your child's sensitivity to the following:

Sound ❍ Normal ❍ Over sensitive ❍ Under sensitive

Other: _____

Odors ❍ Normal ❍ Over sensitive ❍ Under sensitive

Other: _____

Physical touch ❍ Normal ❍ Over sensitive ❍ Under sensitive

Other: _____

Light ❍ Normal ❍ Over sensitive ❍ Under sensitive

Other: _____

Does your child avoid playing with messy substances (finger paints, paste, etc)? ❍ No ❍ Yes

If yes, elaborate: _____

Does your child dislike the feeling of certain types of clothing or material textures? ❍ No ❍ Yes

If yes, elaborate: _____

Does your child seek sensory input/stimulation? ❍ No ❍ Yes

If yes, describe in what way: _____

Does he/she look at things from different angles or track things with his/her eyes? ❍ No ❍ Yes

Does your child get upset with changes in routine or when transitioning from one activity to another? ❍ No ❍ Yes

If yes, please elaborate: _____

Emotional growth

Check any of the following which have been or are currently problems for your child.

Behavior	**Age**, if it is of prior concern
❑ Difficult to discipline	____
❑ Destructive	____
❑ Gets upset easily	____
❑ Aggressive	____
❑ Has temper tantrums	____
❑ Self-injurious	____
❑ Unusually active	____
❑ Prefers to be alone	____
❑ Unusually inactive	____
❑ Unusual difficulty with siblings	____
❑ Thumb sucking	____
❑ Unusually difficulty with peers	____
❑ Nail biting	____
❑ Difficulty with opposite sex	____
❑ Bed wetting	____
❑ Repetitive behavior/play	____
❑ Difficulty sleeping	____
❑ Repetitive body movements	____
❑ Nightmares	____
❑ Repetitive hand movements	____
❑ Masturbating excessively	____
❑ Repetitive use of language	____
❑ Preoccupations	____

Has your child ever worked with a behavioral health clinician or therapist? ❍ No ❍ Yes

If yes, list the name(s), dates and duration of counseling.

Clinician or therapist	**Date**	**Duration**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe how the concerns you have about your child's behaviors impacts his/her ability to interact with others and learn from the environment. How do these behaviors impact the child's well-being and the family's overall function?

_____

_____

_____

_____

NEXT PAGE >

Family details

Parent #1 name: _____

Date of birth: _____ Level of education: _____

Occupation: _____

Parent #2 name: _____

Date of birth: _____ Level of education: _____

Occupation: _____

Relationship between parent #1 and parent #2:

❑ Married ❑ Unmarried ❑ Separated ❑ Divorced

If not married, who has legal custody of the patient?

_____

Sibling #1 name: _____ Date of birth: _____

Sibling #2 name: _____ Date of birth: _____

Sibling #3 name: _____ Date of birth: _____

Sibling #4 name: _____ Date of birth: _____

Sibling #5 name: _____ Date of birth: _____

Who lives in the home with your child?

_____

Family medical history

Please indicate family members and relatives (parents, siblings, grandparents, aunts, uncles or first cousins) who have or had any of the following conditions.

Example: ☑ ADHD Paternal grandfather

❑ ADHD _____

❑ School difficulties/Learning disability_____

❑ Language delay/Communication disorder _____

❑ Autism/PDD/Asperger syndrome _____

❑ Mental retardation_____

❑ Cerebral palsy _____

❑ Seizure disorder _____

❑ Anxiety _____

❑ Depression _____

❑ Alcoholism _____

❑ Substance abuse _____

❑ Other psychiatric disorder_____

❑ Suicidality _____

❑ Deformities or congenital birth defects _____

❑ Muscular weakness _____

❑ Other serious illness _____

❑ Cardiac arrhythmia, heart attack before age 50, or sudden/unexplained death _____

Please include any additional information you would like to add:

_____

_____

_____

_____

_____

_____

_____