Pediatrics at Newton Wellesley Consult Intake Form

Today's Date:	**Patient's PCP:**	
Patient's Name:	**DOB:**	◯ **Adopted** ◯ **Foster Child**
Name of person completing this form/relationship to patient:		

PLEASE COMPLETE THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. THANK YOU

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 SYSTEMS

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

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

Drug Allergies:

Food Allergies:

Birth History *(Full term? Complications during or after pregnancy? NICU stay?)*:

Hospitalizations – *include date(s):*

Surgical Procedures - *includes date(s):*

Indicate any of the following conditions/issues that your child has currently or has previously experienced.		
Disease/Problem	**Age**	**Details**
◯ Seizures / Convulsions		
◯ Headaches / Migraines		
◯ Dizziness / Syncope		
◯ Accidents / Head Trauma / Concussion		
◯ Congenital Heart Disease		
◯ Other Cardiac Conditions		
◯ Hearing / Vision Problems		
◯ GI issues (constipation, diarrhea, vomiting, reflux)		
◯ Sleep disturbance		

GENERAL

Diet:

◯ Regular

◯ Other/Concerns/Dietary Restrictions *(please elaborate)*

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.
Please include age/frequency and duration of all therapies.
(ex: Speech through Early Intervention, once weekly x 1 year beginning at 9 months old)

ACADEMICS

Current School and Grade: _____

Has your child ever had a formal evaluation through school/your town or a private neuropsychological evaluation?
◯ No
◯ Yes – *Please indicate date and person or district who performed the evaluation, and provide a copy of the most recent evaluation):* _____

Date of last IEP or 504:_____

List current services patient receives through school:

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

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 this child? What methods are used?

SENSORY

Indicate your child's sensitivity to the following:

	Normal	Overly Sensitivity	Under Sensitive	Other (please elaborate)
Sensitivity to Sound	☐	☐	☐	
Sensitivity to Odors	☐	☐	☐	
Sensitive to Physical Touch	☐	☐	☐	
Sensitive to Light	☐	☐	☐	

Does your child avoid playing with messy substances (finger paints, paste, etc)?

◯ No
◯ Yes (please elaborate):

Does your child dislike the feeling of certain types of clothing or material textures?

◯ No
◯ Yes (please elaborate):

Does your child seek sensory input/stimulation?

◯ No
◯ 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 (please elaborate):

EMOTIONAL GROWTH

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

Behavior	Age (if prior concern)		Behavior	Age (if 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 - *Please list the name(s), dates and duration of counseling.*

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?

FAMILY DETAILS

Relation	Name	DOB	Level of Education	Occupation
Parent 1				
Parent 2				
Marital Status of Parents (if applicable): ◯ Married ◯ Separated ◯ Divorced *If separated or divorced, who has legal custody of the patient?*				
List all sibling(s) names and DOB:				
Who lives in the home with your child?				

FAMILY MEDICAL HISTORY

Consider patient's immediate family or relatives (i.e. grandparents, aunts/uncles, first cousins).

CONDITION	***RELATIONSHIP TO PATIENT*** *Please indicate specific family member* *(ex: maternal grandfather, paternal cousin)*
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 ☐No ☐ Yes	

Please use the space below for anything that you would like to add.

Behavioral Health Authorization for Disclosure of Clinical Information

Patient Name:_____ **DOB**:_____

I authorize Pediatrics at Newton Wellesley, P.C. to communicate with the following providers, as needed, to help with evaluation, treatment planning and coordination of care:

Person/Agency	**Role** (check one)	**Phone/Fax/Email (if applicable)**
	❑ therapist ❑ medication prescriber ❑ school personnel ❑ other :_____	
	❑ therapist ❑ medication prescriber ❑ school personnel ❑ other :_____	

Pediatrics at Newton Wellesley, P.C. has my permission to release information/records acquired in the course of ongoing mental health assessment, evaluation and/or treatment of the above named patient, including telephone contact and email (if applicable please indicate if consenting to email communication ◯ yes ◯ no). Please check the protected health information below that you are authorizing to be used and/or disclosed:

Details of Mental Health Diagnosis and/or Treatment provided by a Mental Health Provider

- ◯ Social/Family History
- ◯ School Related Information
- ◯ Neuropsychological Reports
- ◯ ER Visits/Hospitalizations
- ◯ Alcohol and Substance Abuse/Treatment*
- ◯ HIV/AIDS Related*
- ◯ Information related to a sexually transmitted infection, sexual activity and/or orientation
- ◯ Other(s): please list _____

*HIV and Substance Abuse information is protected under federal law and must be authorized specifically in order to be use/disclosed.

This authorization will expire with the completion of treatment, unless otherwise changed and/or revoked.

I understand that I may revoke this consent at any time, and that I must notify Pediatrics at Newton Wellesley, P.C. in writing. I understand that such a revocation does not affect any action taken by Pediatrics at Newton Wellesley, P.C. prior to receiving my written notice.

_____ _____

Signature of Patient (or Parent/Guardian) Date

Acknowledgement of electronic signature: ◯ yes ◯ no

_____

Printed Name