

Pediatrics at Newton Wellesley Consult Intake Form

Today's Date:	Patient's PCP:	
Patient's Name:	DOB:	<input type="radio"/> Adopted <input type="radio"/> 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
<input type="radio"/> Seizures / Convulsions		
<input type="radio"/> Headaches / Migraines		
<input type="radio"/> Dizziness / Syncope		
<input type="radio"/> Accidents / Head Trauma / Concussion		
<input type="radio"/> Congenital Heart Disease		
<input type="radio"/> Other Cardiac Conditions		
<input type="radio"/> Hearing / Vision Problems		
<input type="radio"/> GI issues (constipation, diarrhea, vomiting, reflux)		
<input type="radio"/> 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)
<input type="radio"/> Difficult to discipline		<input type="radio"/> Destructive	
<input type="radio"/> Gets upset easily		<input type="radio"/> Aggressive	
<input type="radio"/> Has temper tantrums		<input type="radio"/> Self-injurious	
<input type="radio"/> Unusually active		<input type="radio"/> Prefers to be alone	
<input type="radio"/> Unusually inactive		<input type="radio"/> Unusual difficulty with siblings	
<input type="radio"/> Thumb sucking		<input type="radio"/> Unusually difficulty with peers	
<input type="radio"/> Nail biting		<input type="radio"/> Difficulty with opposite sex	
<input type="radio"/> Bed wetting		<input type="radio"/> Repetitive behavior/play	
<input type="radio"/> Difficulty sleeping		<input type="radio"/> Repetitive body movements	
<input type="radio"/> Nightmares		<input type="radio"/> Repetitive hand movements	
<input type="radio"/> Masturbating excessively		<input type="radio"/> Repetitive use of language	
<input type="radio"/> 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

<u>Relation</u>	<u>Name</u>	<u>DOB</u>	<u>Level of Education</u>	<u>Occupation</u>
Parent 1				
Parent 2				
Marital Status of Parents (if applicable): <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> 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 <i>Please indicate specific family member (ex: maternal grandfather, paternal cousin)</i>
<input type="radio"/> ADHD	
<input type="radio"/> School Difficulties /Learning Disability	
<input type="radio"/> Language Delay/Communication Disorder	
<input type="radio"/> Autism / PDD / Asperger Syndrome	
<input type="radio"/> Mental Retardation	
<input type="radio"/> Cerebral Palsy	
<input type="radio"/> Seizure Disorder	
<input type="radio"/> Anxiety	
<input type="radio"/> Depression	
<input type="radio"/> Alcoholism	
<input type="radio"/> Substance Abuse	
<input type="radio"/> Other Psychiatric Disorder	
<input type="radio"/> Suicidality	
<input type="radio"/> Deformities or Congenital Birth Defects	
<input type="radio"/> Muscular Weakness	
<input type="radio"/> Other Serious Illness	
Cardiac arrhythmia, heart attack before age 50, or sudden/unexplained death <input type="checkbox"/> No <input type="checkbox"/> 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)
	<input type="checkbox"/> therapist <input type="checkbox"/> medication prescriber <input type="checkbox"/> school personnel <input type="checkbox"/> other : _____	
	<input type="checkbox"/> therapist <input type="checkbox"/> medication prescriber <input type="checkbox"/> school personnel <input type="checkbox"/> 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
- Neuropsychological Reports
- Alcohol and Substance Abuse/Treatment*
- Information related to a sexually transmitted infection, sexual activity and/or orientation
- Other(s): please list _____
- School Related Information
- ER Visits/Hospitalizations
- HIV/AIDS Related*

*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

Printed Name

Acknowledgement of electronic signature: yes no