Deanna DeAngelis, LCSW
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Pediatric Intake Form (Ages 4-12)

Last Name of Child: _____ First Name: _____ MI: ____

Date of Birth: _____ Age: _____ Assigned Sex: _____ Gender Id:_____

Address: _____

Today's Date:_____ Guardians Email:_____

Phone Number: _____ All Legal Guardian's Names:_____

Present Mental Health/Behavioral Concerns
Please list your child's health concerns in order of priority, including date of onset and severity of symptoms.
1._____
2._____
3._____
4._____
5._____

What do you believe is causing your child's most important behavioral or mental health concerns?
_____
_____

What goals do you have for your child's visit today?
_____
_____

Name/Number and Address of Primary Care Physician:
_____
_____
_____

Please list all medications, vitamins, supplements, and homeopathic remedies used regularly by your child:
_____
_____
_____
_____
_____

Please list and describe any allergies your child has to medications, supplements, or foods:
_____
_____

Past Medical History: Please list the date of or age at each event and describe:
Serious Illnesses and Injuries:_____

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Surgeries: _____
Hospitalizations: _____

Childhood Illnesses: Your child's health is: □Good □Fair □Poor

Pregnancy History: Birth Mother: # of pregnancies: _____ # of children:_____ Age at delivery:_____
Please check any factors during pregnancy. Health during pregnancy: □ Good □ Fair □ Poor

□ Alcohol Consumption	□ Nausea	□ Toxemia
□ Bleeding	□ Recreational Drugs	□ Trauma/Injury
□ High Blood Pressure	□ Smoking	□ X-rays
□ Stress	□	

Medications_____
Other health problems or complications during pregnancy:_____

Birth History:
□ Full Term □ Early ____ weeks □ Late ____ weeks Length of labor:_____ hours
Place of Birth: □ Hospital □ Birth Center □ Home
□Other:_____
Birth Medications (if any): _____
Complications: _____
Newborn: Weight at birth: _____ lbs _____ oz Home from hospital in _____ days

□ Jaundice	□ Infection	□ Seizures
□ Cyanosis	□ Fever	□ Anemia

Other important conditions: _____
Feeding: □ Breast Fed_____months □ Formula Fed_____ months Type of formula _____

Developmental Milestones: Please indicate your child's age at each milestone:

Sit up _____ months	Walk _____ months	First Word _____ months
Crawl _____ months	First Tooth _____ months	First Sentence _____ months
		Toilet Trained _____ months

Additional comments about social, cognitive, or physical development:_____
_____

Family History:
Have any of the child"s parents, siblings, or grandparents ever had any of the following: (please circle)

Diabetes	Alcoholism/drug abuse	Depression/bipolar
Cancer type_____	Heart attacks/heart disease	High cholesterol
Thyroid problems	High blood pressure	Rheumatoid arthritis/lupus
Stroke	Osteoporosis	Other_____

Social History
Parents: □ Biological □ Adoptive □ Foster □ Step-parent(s)
Name of mom_____ Name of dad_____
Parents' Marital status: □ Single □ Married □ Divorced □ Re-married □ Widowed □

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Significant Other:

Mother's Occupation:_____ Full *or* Part Time Father's Occupation:_____ Full *or* Part Time
Siblings: □ *Yes* □ *No* Please list their names and age(s)_____

_____

Pre-School/Daycare/School:_____ Hours per day:_____ Days per week:_____
Do you have any academic concerns regarding your child?

_____

_____

Personality and Habits:

How does your child react to stressful events? _____
What are your child's primary sources of stress?_____
How much does stress impact your child's life?_____ Hours of play per day? _____
Favorite activities?_____
Does your child:

Exercise regularly? □ Yes □ No What kind?

_____

Sleep soundly and wake rested? □ Yes □ No If no, why?_____
Sleep: _____ hours per night

Naps: _____ hours per day

Play well with others? □ Yes □ No If no, why?_____

Enjoy time alone? □ Yes □ No If no, why?_____

Have sensory sensitivities? □ Yes □ No What kind?

_____

Have strong fears or phobias? □ Yes □ No What kind?

_____

Have rituals/repetitive behaviors? □ Yes □ No What kind?

_____

Diet:

Does your child have any dietary restrictions?_____

Your child's favorite foods? _____

Foods your child refuses? _____

How is your child's appetite?_____ Thirst?_____