

# Lifetime Development

Intake Medical History

Name: \_\_\_\_\_

**Child & Adolescent**

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## Diagnosis at Intake

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

by: \_\_\_\_\_

## Current Medications (incl. dosage)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Past Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Diagnostic Tests

(chromosomes, MRI, EEG, x-ray.. please give dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **REFERRAL SOURCE** & contact info

Name \_\_\_\_\_

City \_\_\_\_\_

Tel \_\_\_\_\_

## General

- Abnormal sensitivity to cold/heat
- Lowered resistance to infection
- Excessive activity level
- Excessive fatigue
- Excessive thirst
- Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Nutrition

- Major food cravings
  - Overweight
  - Increased appetite
  - Recent weight gain
  - Underweight
  - Poor appetite
  - Recent weight loss
  - Concerns about child diet and/or eating habits
- Nutritional supplements your child regularly tasks:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supplements believed to be most beneficial to your child:

\_\_\_\_\_  
\_\_\_\_\_

Types of cookware used:

- Aluminum      Stainless steel
- Pyrex            Glass
- Enamel           Teflon
- Cast Iron        Copper

Drinks tap water    Yes    No

## Toxin Exposure

- Exposure to mercury, lead, toxic chemicals, radiation, etc. (describe)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Towns/cities where child has lived:

\_\_\_\_\_  
\_\_\_\_\_

- Lived in home remodeling project
  - Yes    No

## Gastrointestinal and Hepatic

- Difficulty swallowing
- Nausea or vomiting:
- Abdominal (stomach)/belly pain
- Anal itching

### Bowel Movements

Frequency: \_\_\_\_\_ times per day  
  \_\_\_\_\_ times per week

- Painful
- Infrequent
- Irregular
- Constipation
- Liquid bowel movements
- Loss of bowel control
- Frequent belching or gas
- Rectal bleeding (red or black blood)
- Vomiting blood
- Jaundice (yellowing of skin)
- Other \_\_\_\_\_

## Neurological

- Dizziness; balance problems
- Drowsiness
- Muscle spasms or tremors
- "Tics"

(if so, describe: \_\_\_\_\_)

- Headaches
- Numbness
- Convulsions/fits/seizures
- Weakness in muscles
- Unexplained loss of sensation
- Handedness    R    L    Ambi
- Memory problem(s)
- Pacing
- Other: \_\_\_\_\_

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### Sleep Patterns

Hrs/night sleep (average): \_\_\_\_\_

Normal bedtime: \_\_\_\_\_ M

Normal waking Time: \_\_\_\_\_ M

- Difficulty falling asleep
- Difficulty sleeping
- Excessive sleeping
- Difficulty Awakening
- Awakening in the night due to:
  - Urination
  - Hunger
  - Pain
  - Apnea
  - Other/unknown
- How long to return to sleep: \_\_\_\_\_

- Sleepwalking
- Night Sweats?
- Sleep aids, medications, including natural nutritional supplements.

### Accidents, Trauma, and Surgical procedures

\_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_

### Genitourinary

- Itchy privates or genitals
  - Painful urination
  - Excessive urination
  - Difficulty in starting urine
  - Accidental wetting of self
  - Pus or blood in urine
- Toileting: \_\_\_\_\_

Is your child potty trained?

\_\_\_\_\_  Yes  No

If yes, at what age? \_\_\_\_\_

Bedwetting  Yes  No

Encopresis (soiling)

Yes  No

Other: \_\_\_\_\_

### Musculoskeletal

- Back pain or stiffness
- Joint pain
- Leg pain
- Muscle cramps or pain (describe)
- Neck pain or stiffness
- Other \_\_\_\_\_

### Respiratory

- Asthma, wheezing
- Cough
- Coughing up blood or sputum
- Shortness of breath
- Rapid breathing
- Other: \_\_\_\_\_

### Head, Eye, Ear, Nose & Throat

- Facial pain
- Headache
- Head injury
- Frequent sore throat
- Blurred vision
- Double vision
- Overly sensitive to light
- See spots or shadows
- Hearing loss
- Ear ringing
- Disturbances or sensitivity in smell
- Repeated nose or chest colds
- Runny nose

- Dry mouth
- Sore tongue
- Frequent ear infections
- Age of 1<sup>st</sup> ear infection: \_\_\_\_\_
- Has (or had) ear tubes
- If so, at what ages? \_\_\_\_\_

- Other head, eye, ear, nose, throat: \_\_\_\_\_

### Chest and Cardiovascular

- Rapid/irregular pulse
- Chest pain
- High blood pressure
- Low blood pressure
- Other: \_\_\_\_\_

### Skin, Hair

- Dry hair or skin
- Itchy skin or scalp
- Easy bruising
- Hair loss
- Excessive sweating
- Sun sensitivity
- Acne
- Other: \_\_\_\_\_

### Child & Adolescent

#### **Father's Health:**

*(kindly review & note below any previous items on this checklist for cues to any past & current health issues of father)*

Past: \_\_\_\_\_

Current: \_\_\_\_\_

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## Child & Adolescent

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### Mother's Health:

*(kindly review & note below any previous items on this checklist for cues to any past & current health issues of father)*

Past: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Mother's Pregnancy Information:

- Thyroid problem
- Autoimmunity
- Drug, alcohol or substance use
- Supplements taken during pregnancy
- Flu shot during pregnancy
- Unusual prenatal circumstances

Did you or your spouse engage in any unhealthful practices such as drugs, smoking etc. before conception that may have affected your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_, traumatic events, & unusual stress during pregnancy:  
\_\_\_\_\_  
\_\_\_\_\_

Miscarriages (please give dates): \_\_\_\_\_  
\_\_\_\_\_

### Labor & Delivery:

- Normal
- Unusual Labor: \_\_\_\_\_  
\_\_\_\_\_

Unusual delivery: \_\_\_\_\_  
\_\_\_\_\_

C-section

Apgar score: 1 min. \_\_\_\_ 5min \_\_\_\_

- Neonatal distress
- Neonatal jaundice
- Other neonatal abnormality

### Infant Feeding & Nutrition

- Breastfeeding
- Goat's Milk
- Milk Intolerance
- Formula
- Other
- Colic after eating
- Age food introduced
- Early food intolerance
- Reactions to non-tolerated foods

### Motor Development:

Age of learning to do the following:

Turning over \_\_\_\_\_ mos.

Sitting up \_\_\_\_\_ mos.

Crawling \_\_\_\_\_ mos.

Pulling up \_\_\_\_\_ mos.

Walking unassisted \_\_\_\_\_ mos.

Running \_\_\_\_\_ mos.

Difficulty or delay in coordination:

- Fine (hands, fingers)
- Gross (legs, arms, trunk)
- Unusual motor features

### Language Development:

Does your child make sounds?

- Yes  No

Does your child speak?

- Yes  No

Age of language acquisition

one word \_\_\_\_\_ mos.

sentences \_\_\_\_\_ mos.

Did child lose previously spoken words?  Yes  No

Describe any speech regression:  
\_\_\_\_\_  
\_\_\_\_\_

### Social Interaction:

Date or age of any delay or of any suspected social abnormality or the beginning of plateau or regression in social development \_\_\_\_\_

Please describe circumstances (for example, did this occur following illness, immunization, toxic exposure, or travel?)  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have at least one friend outside the family with whom s/he plays reciprocally?

- Yes  No

Does your child engage you or any other person to share in his or her interests or play?

- Yes  No

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Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Describe your child's current social behavior:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **If child is a toddler:**

Does s/he take an interest in other children?  Yes  No

Does s/he enjoy being swung, bounced on the knee, etc.?  Yes  No

Does s/he like climbing on things, such as up stairs?  Yes  No

Does s/he enjoy playing peek-a-boo & hide & seek?  Yes  No

Does s/he ever pretend, for example, to make a cup of tea using a toy cup & teapot, or pretend other things?  Yes  No

Does s/he ever use his/her index finger for pointing to ask for something?  Yes  No

Can s/he play properly with small toys (cars, bricks, or blocks) without just mouthing, fiddling, or dropping them?  Yes  No

Does your child look you in the eye for more than a second or two?  Yes  No

Does your child ever bring objects over to you (parent) to show you something?  Yes  No

Does your child seem overly sensitive to noise? (e.g., plugging ears)  Yes  No

Does your child smile in response to your face or your smile?

Yes  No

Does your child imitate you? (e.g., you make a face & child imitates)

Yes  No

Does your child respond to his/her name when called?  Yes  No

Does your child look at things you are looking at?  Yes  No

Does your child make unusual finger movements near his/her face?

Yes  No

Does your child try to attract your attention to his/her own activity?

Yes  No

Have you ever wondered if your child is deaf or has a hearing problem?  Yes  No

Does your child understand what people say?  Yes  No

Does your child sometimes stare at nothing or wander with no purpose?  Yes  No

Does your child look at your face to check your reaction when faced with something unfamiliar?

Yes  No

### **For children age 4 & older:**

Please rate the following moods/behaviors for your child on a scale from 1 to 10, where 10 = very poor or having great difficulties and 1 = best imaginable for child's age

Activity Level \_\_\_\_\_

Home behavior \_\_\_\_\_

Self-esteem \_\_\_\_\_

Diet \_\_\_\_\_

Headaches \_\_\_\_\_

Grinding teeth \_\_\_\_\_

Worry/fear/anxiety \_\_\_\_\_

Body tension \_\_\_\_\_

Withdrawal/avoidance \_\_\_\_\_

Mood swings \_\_\_\_\_

Irritability \_\_\_\_\_

Anger/temper \_\_\_\_\_

Aggression \_\_\_\_\_

Eye Contact \_\_\_\_\_

Stubbornness/resistance to requests \_\_\_\_\_

Frustration tolerance \_\_\_\_\_

Contentment/Happiness \_\_\_\_\_

Following directions \_\_\_\_\_

Concentration \_\_\_\_\_

Impulsivity \_\_\_\_\_

Attention \_\_\_\_\_

Distractibility \_\_\_\_\_

Following directions \_\_\_\_\_

Memory \_\_\_\_\_

Drawing ability \_\_\_\_\_

Handwriting \_\_\_\_\_

Math performance \_\_\_\_\_

Reading skills \_\_\_\_\_

Speech level for age \_\_\_\_\_

Speech enunciation \_\_\_\_\_

Voice (normal tone, volume) \_\_\_\_\_

Conversation/  
verbal expression \_\_\_\_\_

Reciprocal play \_\_\_\_\_

Social skill \_\_\_\_\_

Social awareness \_\_\_\_\_

Imaginative play \_\_\_\_\_

Large motor/muscle coordination \_\_\_\_\_

### **Sensory:**

Vision problems, sensitivity \_\_\_\_\_

Hearing difficulties, sensitivity \_\_\_\_\_

Touch abnormalities

Fragrance sensitivities

Difficulties with gauging distance and/or height,

Orientation in space

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- Large motor/muscle coordination \_\_\_\_\_

### Behavior:

- Toe Walking
- Rituals
- Tantrums
- Hand Flapping
- Self-stimulatory behavior:
- Rocking
- Spinning

Please comment on your child's sense of humor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Aspects of child's behavior most troubling to you: \_\_\_\_\_  
\_\_\_\_\_

### Adolescent Female:

- No menses
  - Menstrual Irregularity
- Premenstrual:
- Moodiness
  - Irritability

- Anger
  - Tension
  - Bloating
  - Breast tenderness
  - Cramps
  - Menstrual Headache
- \_\_\_\_\_  
\_\_\_\_\_

Goals for your child's care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Professionals who have diagnosed, worked with, or helped your child (please give names & approx dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What else is important for us to know about your child or your family? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has a school IEP been established for this child patient?

Yes  No

Notes & Additional Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_