Cardinal Glennon
SSM Cardinal Glennon Children's Medical Center

Knights of Columbus Developmental Center
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Patient Label

Intake Questionnaire

This **Intake Questionnaire** contains questions regarding your child's background history, medical/developmental history, and questions regarding services received. Please complete the following questionnaire as thoroughly as possible. If you have any questions about this form, or would like anything to be explained – *please ask our staff for assistance*. When you are finished completing all sections of this form, please return it to our office.

Initial Intake Questions

Has anyone told you your child may have Autism? ☐Yes ☐No Who? _____

Do you have concerns your child may have;

- Autism? ☐Yes ☐No
- ADHD symptoms/behaviors? ☐Yes ☐No
- Limited social skills? ☐Yes ☐No
- Delayed Speech and/or Language Development? ☐Yes ☐No
- Sensory Processing Difficulties? ☐Yes ☐No
- Delayed Fine Motor Skills? ☐Yes ☐No
- Developmental Delays? ☐Yes ☐No
- Psychiatric Issues ☐Yes ☐No

What do you hope to accomplish from this visit? _____

_____

General Information

Child's Name: _____ **Today's Date** _____

Date of Birth: _____/_____/_____ **Gender**: ☐ Male ☐ Female **SS#**_____

Mailing Address: Street: _____

City: _____ State: _____ Zip Code: _____

Phone/Cell Number: _____

Race / Ethnicity: ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic or Latino ☐ other:_____

What Language is Spoken in the home: _____

Insurance: ☐ Medicaid → ☐ Health Care USA ☐ MO Care ☐ Home State ☐ Harmony of IL

☐ Private Insurance (Name of Company): _____

Member ID # _____ Group ID # _____

Primary Care Physician: _____ **Phone Number**:_____ Fax: _____

Parent & Guardian Information

***Parents Names**: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Mailing Address (If different from above): **Father/Mother**

Street: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: (Best number to reach you at) Father _____ Mother _____

***Child's Legal Guardian (s) if other than parent**: _____

Relationship to Child: _____

(Mailing Address (If different than above):

Street: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home/Work/Cell: _____ **Are there any custody disputes about the child?** yes/no

(please bring appropriate documentation)

Child's Caseworker: _____ Phone Number_____

Mailing Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Pregnancy & Birth History

Parents ages at times of birth: Mother _____ Father _____

Pregnancy History:

Complications of pregnancy:

1. **Drink Alcoholic Beverages** ☐Yes ☐No **Smoke** ☐Yes ☐No **Drink Caffeinated Beverages** ☐Yes ☐No
2. Medical Complications: ____None

____ Diabetes **____ High Blood Pressure** **____ Experienced Emotional Trauma** **____ Toxemia**

____ Poor Nutrition **____ Poor Emotional Health** **____ Experienced Physical Trauma**

Birth History: Natural Birth without complications ☐Yes ☐No

Complications of this delivery included: (Check all that apply)

____ Cesarean Section **____ Breech Birth** **____ Complications with umbilical cord**

____ Require Oxygen or mechanical ventilation

Please explain any additional complications: _____

_____

*Baby's weight at birth: _____ *Age when discharged home from hospital? _____

Child's Developmental & Behavioral History

1. As closely as you can recall, please write the age at which your child did the following things:
If your child has not yet reached one of the milestones, please mark the box "not yet."

Motor	Age	Not Yet	Adaptive	Age	Not Yet	Language/Social	Age	Not Yet
Roll Over			Fed Self			Smile back at you		
Sit Alone			Ate Solid Foods			Wave bye-bye		
Crawl			Drank from Cup			Pointed		
Stand Alone			Toilet trained-bladder			Uses single words meaningfully		
Walk Alone			Toilet trained-bowel			Uses short phrases		

Speech and Language History

2. Please estimate your child's present vocabulary size:

☐ no words ☐ 1 - 5 words ☐ 5 - 25 words ☐ 25 - 50 words ☐ more than 100 words

If less than 10 words, please list the words your child does use: _____

_____

3. Does your child:

Name people and objects?	**☐Yes ☐No**	**Use odd phrases or** invented**/made-up words?**	**☐Yes ☐No**
Use short phrases/ sentences?	**☐Yes ☐No**	**Point to make requests/show items?**	**☐Yes ☐No**
Point to body parts?	**☐Yes ☐No**	**Obey simple commands)?**	**☐Yes ☐No**
Repeat what others say?	**☐Yes ☐No**	**Carry out two-step commands?**	**☐Yes ☐No**
Use babble/jargon to communicate?	**☐Yes ☐No**	**Carry on a to and fro conversation?**	**☐Yes ☐No**
Have difficulty expressing needs ?	**☐Yes ☐No**	**Use gestures (point, wave, shrug, nod)**	**☐Yes ☐No**

- **Is your child's speech understood**? By family members: ☐Yes ☐No By Strangers: ☐Yes ☐No

Sensory and Fine Motor Characteristics

12. **Does your child have sensory processing difficulties related to any of the following**? (Please check all that apply)

____ Noise ____Texture ____Taste ____Touch ____Other

If yes, please explain: _____

_____

13. **Does your child have difficulty holding**: spoon/fork **☐Yes ☐No** Pencil/Crayon **☐Yes ☐No** Writing their name **☐Yes ☐No**
14. **Does your child have any *current* feeding/eating problems**? **☐Yes ☐No**

If Yes, how often?_____ Please explain:_____

Social and Behavioral History

4. Does your child (Please check all that apply):

____ **Get along with other children**	____ **Play with other children routinely**	____ **Have friends their own age**
____ **Prefer to be or play alone**	____ **Play social interactive games**	____ **Avoid eye contact**
____ **Initiate play with other children**	____ **Insist on sameness and routine**	____ **Spin objects or self**
____ **Have attachments to odd objects**	____ **Understand social cues**	____ **Exhibit repetitive movements**
____ **Line up toys or objects**	____ **Turn to his/her name**	____ **Show excessive fear or anxiety**
____ **Act aggressively toward others**	____ **Have excessive tantrums**	____ **Show Hyperactivity**
____ **Use too much force with friends**	____ **Trouble paying attention/focusing**	____ **Show Impulsivity**
____ **Have Difficulty regulating self**	____ **Have Difficulty organizing self**	____ **Show affection**
____ **Put non food items in his/her mouth**	____ **Eat a limited variety of foods**	____ **Over interested in certain topics**

5. **What are your child's favorite activities**?_____

6. **Do you have any additional specific concerns about your child's behavior and or development?** ☐Yes ☐No
If Yes, please specify:_____
_____

Child's Educational and Program History

Child's School: _____ **Grade:** _____ ☐ Not in School at this Time
School Phone: _____ **Child's Teacher:** _____

1. Is your child enrolled in any of the following currently or in the past? (check all that apply)

☐ **Parents as Teachers**	☐ **First Steps**	☐ **Head Start**
☐ **Child and Family Connections**	☐ **Daycare/ Preschool**	☐ **Home schooling**
☐ **Regular/Typical Class**	☐ **Regular Class with Resources**	☐ **Fulltime Special Education Class**
☐ **Autism Class**	☐ **Vocational Training**	☐ **Early Childhood Special Education**

3. Has your child ever had prior academic, cognitive, speech and language, or psychological testing? ☐Yes ☐No
If yes, please forward us the most recent copy of the reports prior to your evaluation. Date of testing:_____

2. Does your child currently receive any of the following (check all that apply)? Please indicate where your child receives services.

☐ **Speech Therapy**	☐ **Language Therapy**	☐ **Augmentative Communication**	☐ **Art Therapy**
☐ **Social Skills Training**	☐ **Physical Therapy**	☐ **Occupational Therapy**	☐ **Music Therapy**
☐ **Developmental Therapy**	☐ **1:1 Aide**	☐ **ABA/Discrete Trial**	☐ **Tutoring**
☐ **Relationship Development Intervention (RDI)**		☐ **504 Accommodation Plan**	

☐ **Individualized Education Plan (IEP)** If yes, what is your child's educational determination (diagnosis)?_____

4. Has your child ever repeated a grade? ☐Yes ☐No If yes, which grade? _____

Child's Medical History

1. Please indicate if your child has experienced any of the conditions/illnesses listed:

Neurological		**ENT**		**Gastrointestinal**	
Cerebral Palsy	☐**Yes** ☐**No**	Tonsil/adenoidectomy	☐**Yes** ☐**No**	Acid Reflux/GERD	☐**Yes** ☐**No**
Clumsiness	☐**Yes** ☐**No**	Ear Infections/Tubes	☐**Yes** ☐**No**	Celiac Disease	☐**Yes** ☐**No**
Head Injury	☐**Yes** ☐**No**	**Respiratory/Allergy**		Constipation	☐**Yes** ☐**No**
Meningitis	☐**Yes** ☐**No**	Asthma	☐**Yes** ☐**No**	Diarrhea	☐**Yes** ☐**No**
NF – Type 1	☐**Yes** ☐**No**	Seasonal/Food Allergies	☐**Yes** ☐**No**	Vomiting	☐**Yes** ☐**No**
Seizures	☐**Yes** ☐**No**	**Endocrine**		Colic	☐**Yes** ☐**No**
Tics	☐**Yes** ☐**No**	Diabetes	☐**Yes** ☐**No**	**Cardiovascular**	
Tuberous Sclerosis	☐**Yes** ☐**No**	Thyroid	☐**Yes** ☐**No**	Murmur	☐**Yes** ☐**No**
Staring Spells	☐**Yes** ☐**No**	**Genetic**	☐**Yes** ☐**No**	High Blood Pressure	☐**Yes** ☐**No**
Bladder Problems	☐**Yes** ☐**No**	Please identify _____			

Medical Continued:

2. Please list below any additional illnesses/long-term medical conditions:

Illness/Persistent Condition	Age of Onset	Treatment
_____	_____	_____
_____	_____	_____

3. **Does your child have any *current* sleep problems**? ☐**Yes** ☐**No**
   If Yes, how often?_____ Please explain:_____

4. **Has your child ever had their hearing and/or vision tested/screened**: ☐**Yes** ☐**No**
   Hearing Passed/Failed Date: _____ **Vision** Passed/Failed Date: _____

5. Has your child ever had…? (Please check all that apply and fill in the required information, including dates of screenings)
   - ☐ **MRI of the brain**
     Results _____ Date: _____
   - ☐ **EEG** Asleep/Awake (please circle)
     Results: _____ Date: _____
   - ☐ **Lead level testing**
     Results _____ Date: _____
   - ☐ **Genetic Testing**
     Results: _____ Date: _____

6. **Please list all medications your child is currently taking** including – prescription medications, over-the-counter medications, vitamins, herbs, supplements, or other alternative medicines.
   ☐ **My child is not currently taking any medications**

Name	Dosage	Frequency	Prescribed By

7. **Please list below any food or medication allergies your child has experienced**.

Type of Allergy	Reaction
_____	_____
_____	_____
_____	_____

Psychiatric History (please skip and move on to family history, if no psychiatric history)

Psychiatric History

8. **Have you sought mental health treatment for your child before?** If yes, please provide the treating professional, reasons for treatment, and dates seen.

Name of Mental Health Professional	Reason for Treatment/ Dates Seen
_____	_____
_____	_____
_____	_____

9. **Has your child ever been hospitalized for a psychiatric condition**? If yes, please list the hospitalizations, reasons for hospitalization, and dates of hospitalization below.

Hospital	Dates	Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical/Social History

Social History

1. **Who does your child currently live with?** (please check all that apply)

☐ biological mother ☐ biological father ☐ stepmother ☐ stepfather ☐adoptive mother
☐ adoptive father ☐ foster mother ☐ foster father ☐ biological siblings ☐ step siblings
☐ adoptive siblings ☐ foster siblings ☐ relatives, please specify_____
☐ other, please specify_____
Please list any additional individuals living in the home: _____
_____

2. **If your child has not always lived at home with you, please indicate & describe the different situations he/she has lived in:** (e.g., with other relatives, institutions, foster parents, etc.)

_____
_____

3. **Has your family relocated, moved residence or changed significantly in lifestyle due to job or health-related factors such as promotions, unemployment, acute or chronic illness in family, military service, etc. ☐Yes ☐No**

4. **Please list any current or previous family stressors:**

_____
_____

5. **Has your child experienced any of the following?** (Check all that apply)

Physical abuse (either by an adult or peer)	**☐Yes ☐No**	Alcohol or drug abuse by a parent or sibling	**☐Yes ☐No**
Sexual molestation, sexual abuse	**☐Yes ☐No**	Witnessed violence or abuse of others at home	**☐Yes ☐No**
Emotional abuse or neglect	**☐Yes ☐No**	Serious illness or disability; either the close relative	**☐Yes ☐No**
Death of parent, sibling close relative	**☐Yes ☐No**	Separation from parent for period of time	**☐Yes ☐No**
Removal from the home by DFS	**☐Yes ☐No**	Criminal/ juvenile arrest, or custody dispute by court	**☐Yes ☐No**

____ Other situations that may have been traumatic for child _____

Family Medical History

6. Has anyone in the child's family and/or extended family ever been diagnosed, experienced, or is currently experiencing any of the following? Please *check* the item and state the *relationship* of that person to your child (e.g., parent, sibling, cousin, aunts/uncles, grandparents).

	Relationship to Child		**Relationship to Child**
____ Abuse	_____	____ Irritable Bowel Syndrome	_____
____ Alcohol/Drug abuse	_____	____ Learning problems / disability	_____
____ Anorexia/Bulimia	_____	____ Manic depression / Bipolar	_____
____ Anxiety	_____	____ Neurofibromatosis Type I	_____
____ Asthma	_____	____ Physical Disability	_____
____ ADD/ADHD	_____	____ Schizophrenia	_____
____ Autism Spectrum Disorder	_____	____ School problems	_____
____ Birth Defects	_____	____ Seizures/Epilepsy	_____
____ Brain Tumor	_____	____ Sickle Cell	_____
____ Cancer	_____	____ Speech / Language problems	_____
____ Diabetes	_____	____ Stomach or intestinal ulcers	_____
____ Dementia	_____	____ Thyroid problems	_____
____ Depression	_____	____ Tuberosclerosis	_____
____ Developmental Delays	_____	____ Unexplained/ sudden death	_____
____ Genetic Syndrome	_____	____ Error of metabolism (PKU, galactosemia)	_____
(e.g., Fragile X, Down Syndrome)		____ Intellectual Disability	_____
____ High Blood Pressure	_____	____ Other _____	_____
____ Heart Problems	_____		