

Dr Nicole Andrade Service, DC, CACCP
Intake Form 0-2 Years

DEMOGRAPHIC INFORMATION

Name _____ Today's Date _____
Address _____ Parent Name(s) _____
City, State, Zip _____ Parent Occupations(s) _____
Phone (home) _____
Date of Birth _____ Age _____ Parent Employer(s) _____
Gender: ☐ F ☐ M Height: ____ ft ____ in Weight: ____ Parent Email _____
Medical Doctor _____ Parent Work Phone _____
Date of last check-up _____ Parent Cell Phone _____
Travel time to this office _____ Referred to our office by _____
Name/ Age of Sibling(s) _____
Other Household Members (include extended family, non-family and pets) _____

Name of person responsible for payment of professional services _____
Practitioners at the Lydian Center you have previously seen: _____

CURRENT HEALTH REPORT

What are the primary health or developmental concerns with this child?

1. _____
2. _____
3. _____

BIRTH HISTORY

Was your child adopted? _____ If so, at what age? _____
Term: Full / Premature / Late _____ C-Section? _____ Did mother go into labor? _____ Length of Labor _____
Weight at Birth _____ Birth/fetal pregnancy complications _____
Feeding: ☐ Breast fed How long? _____ ☐ Formula ☐ Milk/Soy Solid foods at age _____
Baby's sleep pattern first year _____
Does child sleep well now? _____
As a baby did this child experience:
☐ Allergies ☐ Colic ☐ Fever ☐ Rashes
☐ Birth Injury ☐ Diarrhea ☐ Jaundice ☐ Seizures
☐ Birth Defects

DEVELOPMENTAL HISTORY

Physical Development

Age began: Rolling over _____ Sitting _____ Crawling _____ Walking _____

Any difficulties with:

☐ Rolling Over

☐ Running

☐ Activities on a Play Structure

☐ Crawling

☐ Somersaults

☐ Gross Motor Activities

☐ Walking

☐ Climbing

☐ Fine Motor Activities

If any difficulties, please explain: _____

Unusual Skills or Interests _____

Sensory Integration Issues

Sensitivity to: ☐ Light ☐ Sound ☐ Smells ☐ Tactile Stimulation ☐ Picky Eater (texture/taste)

Language Development

Age of First Words _____ Sentences _____

Daily Activities

How many hours does your child spend playing out of doors each day? _____

How many hours does your child spend on computer, TV or video time? _____

Favorite Activities: _____

Social Development

Desire and ability to communicate with:

Parents _____ Peers _____ Adults _____

Siblings _____ Older Children _____ Strangers _____

Describe his/her relationships with siblings: _____

Emotional traumas: _____

Extended family (or committed adult family friends) with whom the child has regular contact: _____

Notable developmental histories of biological siblings: _____

DIET

Please describe your child's typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Sweets _____

Food cravings: _____

Any known food, environmental or medication allergies/intolerances? Please list: _____

Does your child routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what?

Artificial colors/sweeteners? _____ Has child ever tried a gluten free/dairy free diet? _____

MEDICAL HISTORY

Injuries

Head injuries _____

Other major falls or injuries _____

Other traumatic events _____

Surgeries/Hospitalizations _____

Infections

Has your child had any of the following:

- | | | | |
|---|---|---|---|
| ☐ Bronchitis | ☐ Tonsillitis | ☐ Measles | ☐ Colic |
| ☐ Croup | number of times ____ | ☐ Mumps | ☐ Persistent Diaper Rashes |
| ☐ Frequent Colds | ☐ Ear Infections | ☐ Rubella | ☐ Bedwetting |
| ☐ Pneumonia | number of times ____ | ☐ Antibiotic Prescriptions | |
| ☐ Chicken Pox | ☐ Scarlet Fever | approximate number in lifetime ____ | |

Immunizations

Has your child had standard childhood vaccinations? ☐ yes ☐ no Any adverse reactions? Please describe:

When your child's condition first appeared, about how long was it after their most recent vaccination, and which vaccination was that? _____

Symptoms

Please write: ☐ = Constantly in the present ☐ = Occasionally in the present ☐ = In the past

- | | | |
|--------------------------|-------------------------|---------------------------|
| _____ acne | _____ bloody urine | _____ joint pains |
| _____ excema | _____ hearing loss | _____ nervousness |
| _____ hives | _____ heart murmur | _____ dizzy spells |
| _____ asthma | _____ anemia | _____ body/breath odor |
| _____ high fevers | _____ stomach aches | _____ motion/car sick |
| _____ chronic rash | _____ constipation | _____ nightmares |
| _____ canker sores | _____ diarrhea | _____ unusual fears |
| _____ sore throat | _____ gas | _____ night sweats |
| _____ wheezing | _____ no appetite | _____ cries easily |
| _____ bleeding gums | _____ insatiable hunger | _____ inconsolable crying |
| _____ nose bleeds | _____ jaundice | _____ excessive fatigue |
| _____ burning urination | _____ bruises easily | |
| _____ frequent urination | _____ flat feet | |

Any other condition not previously mentioned _____

Any current medications (prescription and non-prescription) _____

IMAGING AND SPECIAL STUDIES

	When	Where	Results
Hearing Test	_____	_____	_____
Vision Test	_____	_____	_____
Speech/Language	_____	_____	_____
Behavioral Assessment	_____	_____	_____
X-ray	_____	_____	_____
Other _____	_____	_____	_____

FAMILY HISTORY

Has any immediate family member had any of the following:

- | | | | |
|------------------------------------|--|--|---|
| ☐ Allergies | ☐ Birth Defects | ☐ Diabetes | ☐ Hypertension |
| ☐ Arthritis | ☐ Cancer | ☐ Heart Disease | ☐ Mental Illness |

Health of biological siblings _____

Previous pregnancies by birth mother, miscarriages or complications _____

Mother's health during pregnancy:

- | | | | |
|--|-------------------------------------|---|--------------------------------------|
| ☐ Alcohol consumption | ☐ Drug use | ☐ Nausea | ☐ Tobacco use |
| ☐ Bleeding | ☐ Illness | ☐ Thyroid problems | ☐ Diabetes |
| ☐ Physical/emotional trauma | Mother's age at child's birth _____ | | |

Your completion of this Intake Form will help us determine whether our services might help your child. Upon our review of this Form, we will contact you to set up an initial appointment as a new patient, or, if we believe that the Practice's services may not meet your child's needs, we may offer to discuss possible alternative practitioners. In both cases, we will maintain the information you have provided in this Intake Form in a confidential manner in accordance with our privacy practices, regardless of whether your child becomes a patient of the Practice.

While we may work closely with the practitioner(s) we discuss with you, we are not liable for any care or treatment provided by him/her. In addition, we would like to remind you that you have the right to seek treatment and care for your child from any practitioner at any facility you choose.

Because some of our patients have allergies, we ask you not to wear scented products (e.g., perfumes, hair products, aftershaves, clothing dried with Bounce® dryer sheets) to this office. Please check here to acknowledge this request: ☐