INTEGRATIVE MEDICAL INSTITUTE

PREVENTATIVE & FAMILY MEDICINE
CLINICAL & NEUROPSYCHOLOGY

Pediatric New Patient Paperwork (Ages 2-9)

This questionnaire is to help us understand your child and his/her life more fully. Your answers will enable us to give you greater help with the problems that brought you to us. We realize some things are harder to remember, and others are personal and even difficult to think or talk about. We will treat the information confidentially and none of it will be released to anyone unless you direct us to do so.

This questionnaire is meant to facilitate our services to you and your child. It is used as a tool, not as a final answer to anything. We will discuss this information with you during your consultation, so you'll have a chance to explain further anything you would like. You might want to check ( ) any items you especially want to discuss. Use extra paper if more space is needed for any questions. Thank you for your help.

Child's: _____ Male: ___ Female: ___ DOB: _____
First name Last name

Height: _____ Weight: _____

School name: _____ Grade: ____ Teacher's name: _____

Previous or referring doctor: _____ Date of Last Development Exam: _____

Mother's/Guardian's name: _____
First name Last name

Father's/Guardian's name: _____
First name Last name

Home phone: _____ Cell phone: _____ Work phone: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

E-mail address: _____ Social Security No.: _____

Referred by: Website, Doctor (please give contact information), Other (please explain)

_____

_____

_____

[ ] The email provided will be used for IMI news updates. Check box to opt-out of these emails.

Current Problem

1. In your own words, briefly describe the problem that brings you here:

_____

_____

_____

2. What have you tried to do to solve the problem?

_____

_____

3. How do you feel we can help you with this?

_____

_____

4. Does the child have interpersonal problems with children his or her own age?

YES NO

If YES, explain:

_____

_____

5. Does the child have school problems that concern you currently?

YES NO

If YES, please describe:

_____

6. Is the child usually happy? YES NO
7. Is the child overly anxious or fearful? YES NO
8. Please add any comments you feel might be helpful:

_____

_____

Mother's Health During Pregnancy & Birth History

1. Was Mother in good physical condition during pregnancy?

YES NO

2. If not, what were the difficulties?

_____

_____

3. Were there any problems that made her moody or nervous?

YES NO

If YES, please explain:

_____

_____

4. Did Mother use tobacco, alcohol, caffeine, or any other drugs (including prescribed medications) during the pregnancy?

YES NO

If YES, please describe:

_____

_____

5. Did anyone assist Mother in caring for the baby? YES NO

If YES, who? _____ Relationship: _____

6. Is your child adopted? YES/NO Domestic or International (Country: _____)

Complications during pregnancy?

_____

7. Full-term/Premature? Circle one.

Complications during birth?

_____

Child's birth weight: _____ lbs. ____ oz.

Child's health at birth: _____

Length of hospital stay: _____ Postpartum depression? YES/NO

Health History

1. Childhood illness: (Please circle any that may apply)

   Measles, Mumps, Rubella, Chickenpox, Rheumatic fever, Polio

2. Immunizations and dates:

   Tetanus: _____ Pneumonia: _____ Hepatitis: _____ Chickenpox: _____
   Influenza: _____ MMR Measles, Mumps, Rubella: _____

3. Was your infant: (Please circle any that may apply)

   Calm, Colicky, Difficult to comfort, Easily comforted, Fussy

   Describe: _____

4. Did your child have any difficulties with: (Please circle any that apply)

   Bonding, Feeding, Sleeping, Other

   Describe: _____

5. Does your child have any health issues? YES NO

   Describe: _____

6. Does your child take any medication? YES NO

   Names/Dose/Frequency: _____

   _____

7. Has your child ever had a serious accident, illness, and/or hospitalization? YES NO

   Hospitalizations: _____
   Hospital name and Date

   Reason:

   _____

   Other serious accidents/illnesses: _____
   Date and Location

   Reason:

   _____

8. Did/does your child have:
   -Recurrent ear infections? YES NO

   -Have tubes in his/her ears? YES NO

   Describe:

   _____

9. Did/does your child have allergies?
   Describe:

   _____

10. Did/Does your child have asthma?
    Describe treatment:

    _____

11. Has your child had a: (Please circle any that may apply)

    Hearing screening, Vision screening, Speech/Language screening

    Outcome/Dates: _____

12. Has the child had any difficulties in growth or coordination such as frequent falling, awkwardness, difficulty riding a bicycle, etc.?

    YES NO

13. Has the child ever been evaluated or treated by a psychologist, psychiatrist, or other counselor before?

    YES NO

    If YES, list the names, addresses, and dates (as much as you can):

    _____

14. List any diagnoses or terms that have ever been used to describe your child:

    _____

15. Are you currently concerned that the child might have an undetected or untreated medical problem?

    YES NO

    If YES, describe:

    _____

    _____

Family Information

1. Please list all members of the child's immediate family and provide the information indicated:

Name	Age	Relation to child	Education	Address if different	How person gets along with child

Please add anyone else living in the child's home below:

Name	Age	Relation to child	Education	Address if different	How person gets along with child

2. Is the child much more strongly attached to one parent than the other? YES NO

   If YES, who? _____

3. If the child was adopted, give the age of the child when they came into the home: ____
   a) Date of legal adoption: _____
   b) Does the child know that he or she was adopted? YES NO
   c) When did the child learn about it? _____

4. If the child's parents are not living together, please complete the following:
   a) How old was the child at separation? _____

b) Are the parents divorced? YES NO
c) Has the Father remarried? YES NO
If YES, when? _____
d) Has the Mother remarried? YES NO
If YES, when? _____
e) Whom does the child live with? (Check all that may apply)
Father: _____ Mother: _____ Neither: _____
f) How often does the child see the parent(s) he or she doesn't live with?
_____
g) If the child lives with one stepparent, describe their adjustment to each other and their current relationship:
_____

5. Does the Father have employment outside the home? YES NO
If yes, what is his occupation (be specific):
_____

6. Does the Mother have employment outside the home? YES NO
If yes, what is her occupation (be specific):
_____

7. If the child hasn't always lived in the same house, please list the moves:

City	Age moved away

In order for us to understand your child fully we must know about you and your way of parenting. We feel that understanding how you parent your child requires knowing how you yourselves were parented. The next sections, one to be completed by the Mother and one by the Father, are to help us learn about this.

Mother's Background:

(to be completed by the mother (step-mother, etc.) alone)

1. How many children were in your family? Boys: _____ Girls: _____
2. How many of these were older than you? Boys: _____ Girls: _____

3. Were you raised by both of your parents? YES NO

If NO, please describe who raised you, and for what periods of time:
_____

4. Check one of the following, which best describes your relationship with the woman who raised you mostly (mother, step-mother, etc.):

   Indicate who you're rating: _____
   ____ Always close and warm
   ____ Usually close and warm
   ____ Sometimes close and warm, sometimes distant and cold
   ____ Rarely close and warm, often distant and cold
   ____ Usually distant and cold
   ____ Always distant and cold

5. Check one of the following, which best describes your relationship with the man who raised you mostly (father, step-father, etc.):

   Indicate who you're rating: _____
   ____ Always close and warm
   ____ Usually close and warm
   ____ Sometimes close and warm, sometimes distant and cold
   ____ Rarely close and warm, often distant and cold
   ____ Usually distant and cold
   ____ Always distant and cold

6. Have you ever sought psychiatric or psychological help for yourself?

   If YES, please describe: YES NO
   _____

7. Has any other member of your family had psychiatric or psychological help?

   If YES, please describe: YES NO
   _____

8. Please describe any medical problems or concerns you have:
   _____

9. Have you (or has anyone close to you) ever thought that alcohol or drugs have caused problems for your family?

   If YES, please describe: YES NO
   _____

10. Have you ever had a problem similar to your child's current problem?

    If YES, please describe: YES NO
    _____

11. How did your parents discipline you? Which did it mostly?

_____

12. How do you feel your parents' approach to raising you has influenced your approach with your child?

_____

13. Do you maintain important ties with your family now? YES NO

14. Did your parents have financial problems? YES NO

15. Do you feel you and your family have financial problems? YES NO

16. Please evaluate briefly your strengths and any weaknesses you feel you have as a parent:

_____

17. Please describe briefly your view of your husband's strengths and weaknesses as a parent:

_____

18. Do you feel you have any marital problems that might contribute to your child's problems?
YES NO

If YES, please describe:

_____

19. How do you see your role in resolving the problems that brought you to our clinic?

_____

Father's Background:

(to be completed by the father (step-father, etc.) alone)

1. How many children were in your family? Boys: _____ Girls: _____

2. How many of these were older than you? Boys: _____ Girls: _____

3. Were you raised by both of your parents? YES NO

If NO, please describe who raised you, and for what periods of time:

_____

4. Check one of the following, which best describes your relationship with the woman who raised you mostly (mother, step-mother, etc.):

Indicate who you're rating: _____

____ Always close and warm
____ Usually close and warm
____ Sometimes close and warm, sometimes distant and cold
____ Rarely close and warm, often distant and cold
____ Usually distant and cold
____ Always distant and cold

5. Check one of the following, which best describes your relationship with the man who raised you mostly (father, step-father, etc.):

   Indicate who you're rating: _____

   ____ Always close and warm
   ____ Usually close and warm
   ____ Sometimes close and warm, sometimes distant and cold
   ____ Rarely close and warm, often distant and cold
   ____ Usually distant and cold
   ____ Always distant and cold

6. Have you ever sought psychiatric or psychological help for yourself?

   If YES, please describe: YES NO

   _____

7. Has any other member of your family had psychiatric or psychological help?

   If YES, please describe: YES NO

   _____

8. Please describe any medical problems or concerns you have:

   _____

9. Have you (or has anyone close to you) ever thought that alcohol or drugs have caused problems for your family?

   If YES, please describe: YES NO

   _____

10. Have you ever had a problem similar to your child's current problem?
    If YES, please describe: YES NO

    _____

11. How did your parents discipline you? Which did it mostly?

    _____

12. How do you feel your parents' approach to raising you has influenced your approach with your child?

_____

13. Do you maintain important ties with your family now? YES NO

14. Did your parents have financial problems? YES NO

15. Do you feel you and your family have financial problems? YES NO

16. Please evaluate briefly your strengths and any weaknesses you feel you have as a parent:

_____

17. Please describe briefly your view of your wife's strengths and weaknesses as a parent:

_____

18. Do you feel you have any marital problems that might contribute to your child's problems? If YES, please describe: YES NO

_____

19. How do you see your role in resolving the problems that brought you to our clinic?

_____

Developmental Milestones

1. As accurately as you can remember, how old was your child when he or she:

   Rolled over: ____ Sat up: ____ Crept: ____ Cruised: ____ Crawled: ____

   Walked: ____ Talked (two words): ____ Weaned (Bottle/Breast): ____

   Fed self: ____ Drank from a cup: ____ Toilet Training: ____ Started; ____ Completed

2. Did/does your child dislike any of the following position(s)?

   a) Lying on stomach: YES NO
   Describe: _____
   _____

   b) Lying on back: YES NO
   Describe: _____
   _____

3. How long did your child spend crawling as their main form of mobility?

   _____

4. How was/is your child fed? (Circle all that may apply)

   Bottle, Breast-fed, G-tube

   How long? _____

5. Did/does your child use a:

   Pacifier, Suck thumb, Use a bottle

   If so, how often? _____

6. How would you describe your child's feeding/diet? (Circle all that may apply)

   Normal, Picky Eater, Restricted diet, Poor nutrition,

   Unsafe, Limited

   Other, Describe: (List preferred foods, concerns):

   _____

   _____

7. Do you have concerns about your child's development in any of these areas?
   (Circle all that may apply)

   Speech/Language, Motor Skills, Social Skills,

   Cognitive (Intellectual), Sensory behavior, Emotional

   Describe: _____

8. Does your child have any developmental delays or special needs? YES NO
   Describe: _____

9. Has your child had a developmental or diagnostic assessment? YES NO
   List names of facility, date, and results: _____

   _____

10. Does your child receive any special services (i.e. Speech, O.T., Behavior therapy, etc.)?
YES NO
Describe: _____

Child's Daily Routine

1. What was the best time of day for you with your child?
_____

Diapering/Toileting

2. Is your child toilet trained? YES NO IN PROGRESS

Describe concerns: _____

Dressing/Hygiene/Grooming

3. Does your child get dressed by his/herself? YES NO IN PROGRESS

Describe concerns: _____

a. Does your child have difficulties with tooth brushing, hand washing, washing hair, bathing, or showering?
YES NO IN PROGRESS
Describe concerns:
_____

b. Does your child have difficulties with hair brushing, haircuts, or nail trimming?

Describe concerns: YES NO IN PROGRESS
_____

Sleeping

5. Describe your child 's sleeping arrangement: _____
a. Does your child go to sleep: (Circle all that may apply)

Easily, With difficulty, With a bottle, With a parent, With a bedtime ritual

Describe: _____

b. Does your child have a regular bedtime? YES NO

Wakes at: _____ Naps at: _____ Goes to bed at: _____

Activities and Play

6. What are your child's favorite activities at home? _____
_____

a. Where does your child usually play?
_____

b. Does your child avoid any physical activities? YES NO
Describe: _____

c. Does your child attend any other regular groups or classes? YES NO
Describe: _____

d. Does your child demand a lot of adult attention? YES NO
Describe: _____

Social Relationships

7. Who are the most important people in your child's life?
_____

a. Does your child usually play with: (circle all that apply)

Alone, Siblings, Peers, Younger children,

Older children, Adults

8. When are your child's opportunities to play with other children?
_____

9. Does your child have a hard time making friends?
Describe: _____

10. Which adult does your child spend the most time with?
_____

11. Please describe the child's relationship within the family:
_____

12. Are there any particular concerns in the family about:

Food: _____
Smoking: _____
Drinking: _____
Drugs: _____
Religion: _____
Other issues: _____

If so, please describe: _____
_____

13. Are there any family or neighborhood difficulties, which might be important for us to now in order to understand the present problem with your child?
If YES, explain: YES NO
_____

14. Did the child ever lose any person with whom he or she seemed to be close?

If YES, what was the relationship with that person: YES NO
_____
_____

15. Does the child engage in suitable activities outside school time?

If NO, describe how the time is spent: YES NO
_____

16. Does the child have a pet? YES NO
17. Does the child have assigned responsibilities around the house?
YES NO
18. Does the child complete these responsibilities regularly?
YES NO

Day Care/Preschool

19. Is your child currently in childcare? YES NO

When and where?
_____

20. Is your child currently enrolled in school? YES NO
When and where?
_____

If YES, indicate age begun: ____

Child's reaction:
_____

Parent's reaction:
_____

a. Does your child have an Individualized Education Plan (IEP)? YES NO

b. Did the child have difficulty adjusting to regular school? YES NO

21. Has the child frequently been reluctant to attend school? YES NO

22. Has the child ever had to repeat a grade? YES NO
If YES, which one(s):
_____

23. Do you have concerns regarding school performance? YES NO
Describe: _____

24. Has the school ever reported problems of acting up or disrupting class?

If YES, during which grades: YES NO
_____

25. Has the school ever reported that the child is too shy or withdrawn?

If YES, during which grades: YES NO
_____

26. Has the child seemed to like school?
YES NO

If NO, during which grades:
_____

27. Has the child been achieving about as well as you feel he or she should?
YES NO

a. Indicate the child's typical grades by checking a line on the left.
b. Indicate what grades you feel the child should achieve by checking a line on the right.

Actual Typical	Grades:	Parents' Expectations:
_____	Well above average	_____
_____	Somewhat above average	_____
_____	Somewhat below average	_____
_____	Well below average	_____

28. Does the child participate in suitable extra-curricular school activities?

If YES, please describe: YES NO

_____

_____

29. Has the child ever been evaluated for school or learning problems?
YES NO
If YES, please describe who did the evaluation, the reason, and the results:

_____

30. Has he or she ever been assigned to special classes?
If YES, describe (include ages): YES NO

_____

31. Please describe the child's relationship to other children:

_____

_____

Child's Temperament & Personality

1. How does your child handle separation/transitions?

_____

2. What works best? _____

_____

3. Is your child attached to any special objects? _____

_____

4. Does your child have any fears? _____
_____

5. How does your child express these fears? _____
_____

6. What helps? _____

7. When does your child get upset/angry? _____
_____

8. How does he/she express anger? _____

9. How do you respond? _____
_____

10. Describe your child's typical temperament: (Circle all that may apply)
Energy: Sedentary, Active, Very active

First reaction (to new people, activities, ideas): Avoidant, Shy, Outgoing

Mood (general emotional tone): Anxious, Timid, Curious,
Serious, Happy
Other: _____

Intensity (strength of emotional reactions): Withdrawn, Mild reactions,
Strong reactions

Persistence (ease of stopping when involved in an activity):
Hard, Easily redirected, Hard to focus on an activity

Sensitivity (to noises, emotions, tastes, textures, stress):
Not sensitive, Mild, Very sensitive

Perceptiveness (notices people, noises, objects):
Hardly ever notices, Turns to look, Notices, Overly perceptive

Adaptability (copes with transitions, changes in routine):
Slow, Flexible, Quickly
Describe:
_____

Attention Span/Distractibility:
Describe:
_____

Parent's Comments

1. How would you describe parenting your child?
   _____
2. What do you find the most challenging or stressful in parenting your child?
   _____
3. What kind of discipline do you use and what works best with your child?
   _____
4. What has been most joyful for you in parenting your child?
   _____
5. What are your goals for your child?
   _____
6. Is there anything else you would like us to know about your child?
   _____
7. In regards to your kind of discipline, does this approach achieve the desired results?
   YES NO
8. Do the parents agree on the way the child is being disciplined?
   YES NO
9. Does one parent have the main role of disciplinarian?
   If YES, who: YES NO
   _____

Names of person(s) completing this questionnaire: DATE: _____

_____ _____

_____ _____

Relationship to the child Relationship to the child

Thank you very much for what we know is a big job in completing this questionnaire. Its completion represents an important first step in obtaining the services you are requesting!