

Date _____

MARGARET M. GENNARO, M.D.

Children's Intake Form

Patient's Name _____ Email _____
Last First Middle

Address _____
Street City State Zip

Home Phone () _____ Date of Birth _____ Social Security # _____

If patient is a minor, provide parent's or guardian's name _____

Mother's Work Phone () _____ Mother's Cell Phone () _____

Father's Work Phone () _____ Father's Cell Phone () _____

Name of nearest relative not living with you _____

Address _____ Phone () _____
Street City State Zip

How did you hear about our office? _____

Responsible Party Information – Patient is responsible for bill, your insurance may reimburse you.

Patient's Name _____
(Or parent, if minor) Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Email _____

Date of Birth _____ Social Security # _____ Relationship to Patient _____

Employer Name / Address _____

Spouse's Name _____
Last First Middle

Employer Name / Address _____

Date of Birth _____ Social Security # _____ Work Phone _____

CONSENT

I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1- 1/2 % finance charge (18% APR) may be added to my account.

Patient Signature _____ Date _____

Parent or Responsible Party Signature _____ Relationship _____

INTAKE FORM FOR CHILDREN

Name of Child _____

Briefly state your main concerns about your child and approximately how long you noticed problems:

Family History:

Biological mother's name _____ Age _____ Health problems _____

Biological father's name _____ Age _____ Health problems _____

Mother's name (if different) _____ Age _____ Health problems _____

Father's name (if different) _____ Age _____ Health problems _____

Please check off if there is any history in the extended family of these diseases and who suffers from it:

Developmental disabilities _____

Mental illness _____

Genetic diseases (i.e. Tay-Sachs, cystic fibrosis) _____

Diabetes or other metabolic disorders (i.e. thyroid) _____

Abnormalities of the heart _____

Abnormalities of the lungs _____

Drug abuse _____

Alcohol abuse _____

High blood pressure _____

Kidney disease _____

Deafness _____

Cancer _____

Arthritis _____

Asthma _____

Allergies _____

Intestinal problems (i.e. ulcerative colitis, Crohn's) _____

Siblings:

Full- Name _____ Age _____ Health problems _____

Name _____ Age _____ Health problems _____

Name _____ Age _____ Health problems _____

Name _____ Age _____ Health problems _____

Half- Name _____ Age _____ Health problems _____

Name _____ Age _____ Health problems _____

Who does the child reside with? _____

Type and quantity of pets _____

Has there been marriage between close relatives?

No Yes, _____

Are there any physical abnormalities in close relatives that your child resembles?

No Yes, _____

Pregnancy History:

Length of pregnancy _____ weeks

Was pregnancy supervised by a doctor? No Yes, _____

Any drugs (Rx, OTC, or other) during pregnancy? No Yes, which: _____

Any tobacco use during pregnancy? No Yes, how much per day? _____

Any alcohol during pregnancy? No Yes, How much? _____

Were there any complications during pregnancy? No Yes, Be specific: _____

Were there any drugs used during labor? No Yes, what kind, if known _____

Labor was: Induced Spontaneous

What kind of anesthesia did mother require? Epidural General

How long was labor? _____

Were there any complications during labor or delivery? No Yes, be specific _____

What kind of delivery? Vaginal Headfirst Breech
 C-section , for what reason? _____

What were baby's Apgar scores, if known? _____ Birth Weight _____

Was there anything unusual about how your child looked after delivery? No Yes, be specific _____

Did your child cry spontaneously, move arms and legs immediately after birth? No Yes
If no, what resuscitation was given? _____

Developmental History:

Was child breast fed? No Yes, for how long? _____

Was child bottle fed? No Yes, what formula(s)? _____

Did your child have trouble sucking? No Yes

Did your child have colic or problems with any formula? No Yes, please be specific _____

Age when child sat? _____

Age when child stood holding on? _____

Age when child walked? _____

Did child crawl normally? No Yes
If no, how ? _____

Age when child spoke two-word sentences? _____

At what age could you tell if child was left or right handed? Less than 1 year
 1 – 2 years old
 over 3 years old

Vaccinations received and how many (if known) **If can, please bring in shot records.**

DPT _____ DT _____ DtaP (Acellular DPT) _____

MMR _____ Hepatitis B _____ HIB (Haemophilus Influenza type B) _____

Rotavirus _____ Chicken Pox _____ IPV (Inactivated polio) _____

OPV (Oral polio) _____ Other _____

Has your child had any unusual reactions to any vaccine? Be specific _____

Do you have any developmental concerns about your child? _____

Medical History

Any hospitalizations? No Yes, for what conditions and dates? _____

Any surgeries? No Yes, for what conditions and dates? _____

If your child has had anesthesia, have there been any complications?
 No Yes, be specific _____

Does your child have any allergies?
 No Yes, be specific _____

Has your child ever had a concussion or head injury?
 No Yes, explain _____

Has your child ever been involved in a significant accident?
 No Yes, explain _____

Has a physician ever noted that your child exhibits any structural or biochemical abnormalities? What? _____

Has your physician ordered any medical evaluations or tests?
 No Yes, what were results? (Please bring them in) _____

Has your child had any of the following symptoms? Please check off category and circle the specific problem.

- | | |
|--|--|
| <input type="checkbox"/> Difficulty gaining/losing weight or obsession with weight | <input type="checkbox"/> Compulsive eating |
| <input type="checkbox"/> Frequent headaches, stomachaches or other pains | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Frequent diarrhea, constipation, nausea, gas, vomiting, heartburn or bloating | <input type="checkbox"/> Frequent yeast infections (vaginal, diaper or thrush = mouth) |
| <input type="checkbox"/> Chest pains, palpitations, irregular heart beat, heart murmur | <input type="checkbox"/> Itching (skin, genitalia, anus) |
| <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Frequent episodes of dizziness |
| <input type="checkbox"/> Frequent episodes of breathlessness | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Prolonged fatigue |
| <input type="checkbox"/> Significant snoring | <input type="checkbox"/> Trouble waking up in the morning |
| <input type="checkbox"/> Frequent colds, ear or sinus infections, bouts of the flu | <input type="checkbox"/> Eczema or psoriasis |
| <input type="checkbox"/> Asthma (bronchospasm, reactive airway disease), bronchitis | <input type="checkbox"/> Coughing or shortness of breath during exercise |
| <input type="checkbox"/> Hives, rashes | <input type="checkbox"/> Tics such as grimacing or twitching |
| <input type="checkbox"/> Dark circles under eyes / lines under eyes / frequent sneezing / frequent rubbing of nose | <input type="checkbox"/> Bedwetting (after being toilet trained) day or night / soiling self |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Excessive acne |
| <input type="checkbox"/> Excessive ear wax | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Distractibility |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> For girls: abnormal vaginal discharge |

Have you noticed any of the following? (please check category and circle specific problem)

- | | |
|---|--|
| <input type="checkbox"/> Abnormal gait when walking, running, hopping, skipping or climbing stairs | <input type="checkbox"/> Abnormal posture |
| <input type="checkbox"/> Child sweats excessively after meals | <input type="checkbox"/> Child tires more easily than other children |
| <input type="checkbox"/> Child reacts to any foods (sugar, chocolate, colorings, milk, eggs, wheat, corn, others) | <input type="checkbox"/> Child gets very irritable/aggressive/shaky if meals are delayed |
| | <input type="checkbox"/> Child feels better after meals |
| | <input type="checkbox"/> Uncoordinated at sports or particularly clumsy |

- Poor fine-motor control (difficulty coloring, writing, Picking up small objects)
- Child craves certain foods, which? _____
- Child's dominant hand is different from parents

- Child eats non-food items (paste, dirt, crayons, laundry detergent, other)
- Child writes with right hand and kicks with left foot or vice versa

Has child gotten any tattoos? No Yes, when and by whom? _____

Have you noted your child exhibits any of the following (please check off category and circle specific problem)

- | | |
|--|--|
| <input type="checkbox"/> Head (abnormal shape, other) | <input type="checkbox"/> Eyes (visual problems, squinting, itchy, other) |
| <input type="checkbox"/> Ears (hypersensitivity to noise, hearing loss, pulling on ears, red ears, oddly shaped or placed, other) | <input type="checkbox"/> Nose (cold sores or fever blisters, teeth grinding, frequent throat clearing, abnormal tongue, other) |
| <input type="checkbox"/> Facial features (abnormal) | <input type="checkbox"/> Skin (dark or light patches, other unusual markings) |
| <input type="checkbox"/> Hair (unusual coarse/dry or fine, hair whorl on same side as dominant hand, whorl in the middle of head, two hairs whorls, hair loss) | <input type="checkbox"/> Fingernails or toenails (brittle, white spots, ridged, discolored, misshapen, other) |
| <input type="checkbox"/> Fingers or toes (webbing between toes, unusually long or short fingers or toes, other) | <input type="checkbox"/> Joints (double-jointed, pain in joints, other) |
| | <input type="checkbox"/> Genitalia (abnormally large or small, malformed) |
| | <input type="checkbox"/> Handedness (no hand preference, has switched hand preference or does not use one hand at all, other) |

Activities (please check off category):

- You or your spouse work jobs that expose you to lead or other pollutants (car repair, battery repair, smelting, stained glass work, home restorations, painting, pest control, farming or industrial jobs involving lead-cadmium)
- You/spouse/child do extensive gardening or yard work
- Your house is heated with gas/ you smell gas in your house/ your furnace has not been checked in over 2 years
- You do not have a carbon monoxide detector and smoke detector
- Your house has not been checked for radon gas (an odorless, tasteless, invisible gas)
- Family hobbies include shooting, model building, car restoration, furniture refinishing or other activities involving solvents, glues, paints or other chemicals
- Live in an older home (over 20 years), have peeling, chipped paint or have done any large scale renovations including sanding old paint on walls or sanding floors
- Your house contains lead-based paints
- You have traveled or lived in any foreign country? Which? _____ and if so, how hygienic were your living conditions? _____
- If you traveled outside the U.S., did your child or any family member become ill? (i.e. diarrhea)
- Your child takes any Rx or OTC drugs regularly now or recently. Please list:

- Your child takes any ethnic or herbal remedies or any supplements, including vitamins. List

- Your child swims or plays in a pond now or in the past. When? _____

Cognitive/Social History

- You have concerns about your child's speech (too fast, too slow, difficult to understand, not appropriate for age, stuttering, lisp, other)
- Your child speaks another language. If so, what age did your child begin speaking English? _____
- More than one language is spoken at home. If so, what language? _____

Does your child have frequent nightmares or “night terrors”?

No

Yes, how often? _____

Is your child difficult to waken when he/she is sleeping?

No

Yes

Morning:

What time does your child awaken? _____

Does your child eat breakfast?

No

Yes

After breakfast, does your child feel?

Good

Behavior regression, irritable

Tired or sweaty

Don't know

Does your child nap in the morning?

No

Yes, for how long? _____

Describe what your child's behavior, mood and energy level is like in the morning? _____

Does your child eat a morning snack?

No

Yes, what? _____

Does it appear to affect your child's mood or energy level?

No

Yes

If your child goes to school,

Walk

Car

Bus

how does he/she get there?

Bike

Other

Do you notice your child has tantrums

in the morning?

No

Yes, what time? _____

Ask your child's teacher to assess your child's morning behavior/mood/energy level, particularly compared to that of other children. _____

Afternoon: (prior to 3 p.m.)

Does your child eat lunch?

No

Yes

What time does your child eat lunch? _____

What does he/she eat and drink? _____

Does your child feel weak or irritable or shaky before lunch?

No

Yes

Don't know

How does your child feel after lunch?

Good

Tired or sweaty

Don't know

Other _____

Does your child nap during the afternoon?

No

Yes, for how long?

Describe what your child's mood, behavior and energy level is like in the afternoon, _____

Does your child eat an afternoon snack?

No

Yes, what? _____

Does the snack appear to affect your child's mood or energy level?

No

Yes, in what way? _____

Does your child have tantrums in the afternoon?

No

Yes, what time? _____

Ask your child's teacher to assess your child's afternoon behavior, mood and energy level particularly as compared with that of other children _____

Late afternoon: (After 3 p.m.)

How does your child get home from school?

Walk

Car

Bus

Bike

Describe what your child's mood, behavior and energy level is like when he/she gets home? _____

Does your child snack upon getting home?

No

Yes, what? _____

What does your child drink in the afternoon? Please check of category, circle specific and give approximate quantities.

- Caffeinated soda (i.e. Coke, Pepsi, Mountain Dew, others) _____
- Decaffeinated soda (7-up, Sprite, others) _____
- Iced tea (sweetened or unsweetened) _____
- Diet soda (diet Coke, diet Sprite, Crystal Light, others) _____
- Juice (orange, apple, Capri-Sun, Kool-Aid, others) _____
- Milk (whole, 2%, 1% or skim, soy, rice, almond, others) _____
- Water _____

How many hours of TV does your child watch before dinner? _____

What other activities does your child participate in before dinner?

- Homework Sports Computer or video games
- Hobbies Other _____

Does your child do homework in the late afternoon? No Yes

If yes, how long does homework before dinner take?

- Less than 30 minutes 30 – 60 minutes 1 – 2 hours over 2 hours

Do you need to help your child with homework?

- Rarely Sometimes Many times All the time

What is your child's behavior immediately before dinner? _____

Does your child have tantrums in the late afternoon? No Yes, when? _____

Evening:

What does your child eat/drink for dinner? _____

How good is his/her appetite? _____

How does your child feel after dinner? Good Fatigued or sweaty Don't know Other

What are your child's behavior, mood and energy level after dinner? _____

Does your child have tantrums in the evening? No Yes, when? _____

How many hours of TV does your child watch in the evening? _____

What activities does your child participate in during the evening?

- Homework Sports Computer or video games
- Hobbies Other _____

Does your child do homework in the evening? No Yes

How long does homework take to complete?

- Less than 30 minutes 30 – 60 minutes 1 – 2 hours over 2 hours

Does your child have a snack before bedtime? No Yes, what? _____

What does your child drink in the evening? Please check category, circle specific and give approximate quantities.

- Caffeinated soda (i.e. Coke, Pepsi, Mountain Dew, others) _____
- Decaffeinated soda (7-up, Sprite, others) _____
- Iced tea (sweetened or unsweetened) _____
- Diet soda (diet Coke, diet Sprite, Crystal Light, others) _____
- Juice (orange, apple, Capri-Sun, Kool-Aid, others) _____
- Milk (whole, 2%, 1% or skim, soy, rice almond, others) _____
- Water _____

Parents feel (circle all that apply): frustrated, guilty, helpless, depressed, angry, tired, hopeless, at the end of my rope, other _____

Person filling out this form _____

Please feel free to make any additional comments that might be helpful to me.

Childhood Symptom Questionnaire

Rate each of the following symptoms based upon the child's current health profile.

0 = never or almost never has the symptom

1 = Occasionally has symptom

2 = Frequently has symptom

Digestive Tract/Urinary:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Passing Gas | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Bloating | <input type="checkbox"/> Refusal to eat |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Fatigue, lethargy | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Itching of anus or genitals | | | |

TOTAL: _____

Ears:

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Reddening of ears | <input type="checkbox"/> Itchy ears | <input type="checkbox"/> Earaches/Ear infections |
| <input type="checkbox"/> Drainage from ears | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Drainage from ears |

TOTAL: _____

Skin:

- | | | | | |
|--|--------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Hives | <input type="checkbox"/> Rash | <input type="checkbox"/> Dry or flaky skin | <input type="checkbox"/> Eczema |
|--|--------------------------------|-------------------------------|--|---------------------------------|

TOTAL: _____

Mind/Emotions:

- | | | |
|--|--|---|
| <input type="checkbox"/> Inattentiveness or poor concentration | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety, nervousness, fear |
| <input type="checkbox"/> Anger, irritability | <input type="checkbox"/> Aggressiveness (hitting, kicking, biting, etc.) | |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Headaches |

TOTAL: _____

Nose/Eyes/Lungs:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Watery or itchy eyes |
| <input type="checkbox"/> "Allergic Salute" (rubs, itches, wipes nose) | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Bags under eyes | |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Difficulty breathing | |

TOTAL: _____

GRAND TOTAL: _____