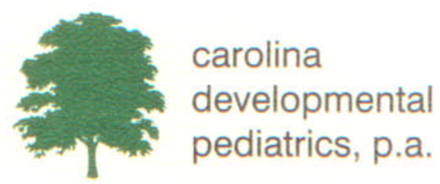

INITIAL INTAKE FORM (PARENT)

DEMOGRAPHIC INFORMATION:

Child's Last Name____________________________ Child's First Name_______________________ MI_______

Address ____ City ________________State _________ ZIP _____________

E-mail address: ____ Home Phone (___)____________________

Parent Work Phone (___)____________________ Parent Cell Phone (___)________________

Patient Birth date:______/______/______ Sex: M F (Circle one)

Emergency contact: ____

Home phone: _________________________________ Cell phone ________________________

Primary Insurance (circle one): **BCBSNC** **Aetna** **Cigna** **Medicaid** **Other :** ______________________

Is Referral or Pre-authorization required: **Yes No** (circle one)

Primary Insurance Holder: _________________________________ Employer : ____________________________________

Insurance ID number:____________________________ Group number: _____________ Holder's Date of Birth _______________

REFERRAL CONCERNS:

Please indicate what concerns you have regarding your child.

1 ____

2 ____

3 ____

4 ____

Additional Information:

____

____

____

____

____

____

____

Who referred you to us? ________________________________ Primary MD: _________________________________

1001 W. Williams St., Suite 104 • Apex, NC 27502
tel. 919.362.5406 • fax 919.362.5409

Please help us understand more about your child by completing the following sections:

PREGNANCY	Yes	No	Comments
Was the pregnancy planned?	___	___	___
Was prenatal care begun in the first trimester?	___	___	___
Were medications used during pregnancy?	___	___	___
Did the mother drink any alcohol? (how much)	___	___	___
Did the mother smoke cigarettes? (how much)	___	___	___
Did the mother use illicit drugs? (if yes, indicate)	___	___	___
Were there any problems during the pregnancy?	___	___	___

BIRTH	Yes	No	Comments
Was the birth full term? (if not how many weeks)	___	___	___
Was the delivery a cesarean?	___	___	___
Were there any problems with delivery?	___	___	___
What was the birth weight?	________ lbs. _______oz.		
Were there any difficulties at birth?	___	___	___
Was the child a twin or triplet?	___	___	___
Were there any birth defects noted?	___	___	___
Were there any feeding difficulties?	___	___	___
Did the child stay in the hospital longer than 3 days?	___	___	___
Were there any other problems?	___	___	___

PAST MEDICAL HISTORY	Yes	No	Comments
Did the child have frequent ear infections?	___	___	___
Did the child have any serious infections?	___	___	___
Is there a history of poor weight gain?	___	___	___
In the past have there been any difficulties with hearing?	___	___	___
In the past have there been any difficulties with vision?	___	___	___
Does the child suffer from allergies? (If so to what)	___	___	___
Have there been difficulties with bowel movements?	___	___	___
Have there been difficulties with urination/bedwetting?	___	___	___
Does the child take any medications/supplements?	___	___	___

List

1 ______________________________

2 ______________________________

3 ______________________________

Has child had any surgeries?	___	___	___
Has the child ever been hospitalized?	___	___	___
Are there other medical problems?	___	___	___

REVIEW OF SYSTEMS	Yes	No	Comments
Does the child have difficulties with any of the following?	___	___	___
Headaches	___	___	___
Stuffy nose	___	___	___
Trouble breathing	___	___	___
Noisy breathing during sleep	___	___	___
Trouble falling or staying asleep	___	___	___
Daytime sleepiness	___	___	___
Difficulty getting going in the morning	___	___	___
Constipation	___	___	___
Loose stools	___	___	___
Difficulty hearing	___	___	___
Difficulty with vision	___	___	___
Frequent stomachaches	___	___	___
Bedwetting	___	___	___
Staring spells	___	___	___
What time does the child go to sleep?	___		pm
What time does the child wakeup?	___		am

DEVELOPMENTAL HISTORY	Yes	No	Comments
Was early development normal/typical?	___	___	___
Has the child lost any skills?	___	___	___
Please indicate the age at which the child:			
Rolled over	___		mos.
Sat up alone	___		mos.
Crawled	___		mos.
Walked alone	___		mos.
Ran well	___		yrs.
Rode tricycle	___		yrs.
Spoke first words	___		mos.
Put two words together	___		mos.
Spoke so others could understand	___		yrs.
Able to hold the bottle	___		mos.
Used a spoon to feed self	___		mos.
Was able to tie shoes	___		yrs.
Could dress independently	___		yrs.

Comments:

___

___

FAMILY HISTORY

Anybody in the family been diagnosed with any of the following?

	Yes	No	Comments
Attention Problems ADHD	___	___	________________
Autism	___	___	________________
Developmental delay/mental retardation	___	___	________________
Learning problems/dyslexia	___	___	________________
Depression	___	___	________________
Anxiety	___	___	________________
Bipolar disorder	___	___	________________
Other psychiatric problems	___	___	________________
Thyroid	___	___	________________
Hearing problems	___	___	________________
Vision problems	___	___	________________
Bedwetting	___	___	________________
Other :	___	___	________________

SOCIAL HISTORY

	Yes	No	Comments
Does the child live with their biological parents?	___	___	________________
Does the child have any brothers? (List ages)	___	___	________________
Does the child have any sisters? (List ages)	___	___	________________
Does the child attend school or day care?	___	___	________________

Name of school or day care: ____________________ Grade: ____________

Please list some of the child's favorite activities:

____

____

____

How old is the child's mother? ____________ years old Occupation: ____________________

How old is the child's father? ____________ years old Occupation: ____________________

PREVIOUS ASSESSMENTS

Type Date Result

____

____

____

____

____

____

Please mail to us at 1001 W. Williams Street Suite 104, Apex, NC 27502 or fax back at 919-362-5409

Directions to our office

Carolina Developmental Pediatrics is located in the Apex Medical Park south of the Beaver Creek Commons shopping center approximately half a mile south of US 64 on W. Williams St. (NC 55) in Apex.

If you are **coming from the North** you will pass Carrabas Italian Restaurant on your right hand side. The next driveway leads into the Apex Medical Park.

If you're **coming from the South** on NC 55 (W. Williams St.), after you cross over Olive Chapel Road/ Hunter St. and go through the traffic light at Apex Peakway Look for the Apex Medical Park on your left hand side. If you reach the Beaver Creek Commons Shopping Center you have gone too far.

Our building is the first one on the left-hand side and we are in Suite 104. The complete address is 1001 W. Williams St. Apex, NC 27502.

Insurance and financial arrangements

Carolina Developmental Pediatrics, PA participates in a number of insurance networks including:

- Blue Cross Blue Shield of North Carolina
- Aetna
- CIGNA
- Medicaid

While we try very hard to keep up-to-date on all of the insurance benefits, it is hard to know your exact benefits. **We encourage families to find out about their benefits prior to their office visits particularly as they relate to potential conditions such as attention deficits, learning difficulties, and behavioral problems.** Many insurers require that you used specific behavioral health networks. Please feel free to call our office if you have any questions.

Please bring your insurance card, copies of previous testing, and any other pertinent information that pertains to your child's presenting concerns.