

**Challenged Child and Friends, Inc.
Health Intake**

Child's Name:	D.O.B.:
Date:	Diagnosis:

Maternal History: Mother's Age At Delivery: _____
Prenatal Care: Where: _____
When begun: No prenatal care _____ 1st trimester _____
2nd trimester _____ 3rd trimester _____
Frequency of care: _____

Problems: Maternal diseases/conditions during pregnancy: _____

Medications during pregnancy: _____

Drug/Alcohol use during pregnancy: Yes _____ No _____ Reason: _____
Frequency/Amount: _____

Smoking during pregnancy: None _____ 1 pack/day _____ 2 pack/day or more _____

Amniocentesis: Yes _____ No _____ Reason _____

Ultrasound: Yes _____ No _____ Reason _____

Labor/Delivery:
Weeks gestation: _____ Birthplace: _____
Length of labor (hours: _____ Natural _____ Caesarian Section _____
Was labor induced? _____ Forces used? _____ Anesthesia? _____
Was labor difficult? _____ Number of previous pregnancies _____
Did mother have problems with delivery? _____

Neonatal History: Birthweight: _____ Apgar Rating: _____ Breathe Spontaneously? _____

Anything exceptional in baby's condition: _____

Ability to suck? _____ Breast fed _____ Bottle fed _____

Did baby have problems after birth? _____

Transferred to another hospital / NICU ? Yes _____ No _____

Accidents/Illnesses/Operations:

Date	Age	Circumstance

Childhood Illnesses (i.e. Fifth Disease, Chicken Pox, etc.): _____

Seizures: Yes _____ No _____ Seizure History Completed _____

Child's Name:	D.O.B.:
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All Medications (even those taken at home and as needed): _____

All Allergies/Type of Reaction: _____

List all physicians your child sees and why (Orthopedist, Neurologist, etc...): _____

Vision/Hearing: _____

Present Health Status: _____

Does your child have any of the following potential risks we should be aware of? If marked, please explain.

- | | | | |
|-------------------------|------------------------|-----------------------|-----------------------|
| _____ Chokes easily | _____ G-Tube or button | _____ Heart Condition | _____ Hip Dislocation |
| _____ Shunt | _____ Skin Breakdown | _____ Tires Easily | _____ Tracheotomy |
| _____ Elbow Dislocation | _____ Other | | |

Explanations: _____

Do you expect your child to have any surgery in the near future? Yes _____ No _____

If you answered 'yes', please explain: _____

Is your child followed by private or public clinics, agencies [i.e. Babies Can't Wait, GA Pines, Hand in Hand, etc.]?

Yes _____ No _____

If yes, please list the clinic/agency's name, and any contact person: _____

Developmental History: [please indicate approximate age each of the following occurred]:

- | | |
|------------------------|--------------------------|
| _____ sat unsupported | _____ cruised |
| _____ crawled | _____ first words |
| _____ stand holding on | _____ 2-3 words together |
| _____ walked | _____ toilet trained |

Anything unusual in your child's development which you feel is important for us to understand? _____

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Current Functioning:

Other therapy providers/days of service: _____

Any medical restrictions? _____

Gross Motor: _____

Fine Motor: _____

Language/Communication: _____

Social Interaction: _____

Feeding Skills/Special Diets/Feeding Instructions: _____

Toileting/Bowel/Bladder/Diapers _____

Ointment of Choice: _____

Sleeping Habits: _____

Adaptive Equipment:

Wheelchair Walker Orthosis Augmentative Devices Hearing Aids
 Glasses Other (please explain) _____
 Any equipment needed that is not already being used: _____

Medical Devices:

- Tracheostomy: Type _____ Size _____ Oxygen _____
Date of Placement _____
- Gastronomy Tube: Type _____ Size _____ Date of Placement _____
- Porta Cath: Type _____ Size _____ Date of Placement _____
Reason for cath _____
- Pacemaker: Type _____ Model _____ Date of Placement _____
Parameter Settings _____ Electro Cardiologist _____
- Apnea Monitor Type _____ Model _____ Date of Placement _____
Parameter Settings _____
- Ventricular/Peritoneal Shunt Date of Placement _____ Date of Revisions _____
Symptoms of Blockage _____
- Colostomy Type of Bag _____ Size _____ Date of Surgery _____
Reason _____
- Vagal Nerve Stimulator Date of Placement _____
- Baclofen Pump Date of Placement _____

Signature of parent/guardian authorizes placement of intake form in child's agency records

Parent/Guarding Signature _____ Date _____