Pediatric Sleep Adoption and Development
dBa Ocean Sleep Medicine
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NEW PATIENT INTAKE FORM (0-5 y/o)

Complete **BEFORE** your child's appointment. This helps for a more focused visit to address your concerns. Also, if your child has had any evaluations from school or other centers, please bring so that Doctor or Nurse Practitioner can review.

PATIENT INFORMATION

Child's Name: _____ Birth Date: _____

Gender: _____ Age: _____

ALL Parents or Legal Guardians:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

PURPOSE OF CONSULTATION

Why are you seeking help for your child? List main concerns:

_____

_____

What would you like our center to do for your child, or family?

_____

_____

What attempts have you made already to address these problems (other professionals, medications, therapies)?

_____

_____

PREGNANCY HISTORY

Was the mother under the care of a doctor? ☐ Yes ☐ No

Did the mother take any of the following during pregnancy?

☐ Alcohol ☐ Drugs:_____

☐ Cigarettes/Nicotine ☐ Medications: _____

Please check any of the following complications that occurred during the pregnancy:

☐ Difficulty getting pregnant ☐ Infections ☐ Hospitalization required

☐ Bleeding ☐ Diabetes ☐ X Rays

☐ Excessive vomiting ☐ Abnormal weight gain

Other: _____

BIRTH HISTORY

Birth weight: _____ lbs _____ oz Head Circumference: _____ cm Length: _____

Length of pregnancy: Full term Post term Pre term, delivered at _____ weeks

Length of Hospital stay: Mother: _____ Child: _____

Please check any of the following complications:

- ☐ Forceps used ☐ Breech position ☐ Labor induced
- ☐ C- Section, due to: _____
- ☐ Jaundice ☐ Breathing problems ☐ Required Oxygen
- ☐ Other complications: _____
- ☐ NICU for _____ weeks; NICU treatments included: _____

CHILD'S MEDICAL HISTORY

Normal hearing evaluation? ☐ Yes, date: _____ ☐ No, _____

Normal vision evaluation? ☐ Yes, date: _____ ☐ No, _____

Immunizations are up-to-date: ☐ Yes ☐ No, missing: _____

Does your child take any medications (currently or in the past) ☐ Yes ☐ No

If yes please complete following:

Medication Name:	Dose	Dates/ages medication was taken	Reason for taking medication	Side effects or reason for stopping.

Please check any of the following medical problems your child has had:

☐ Wears glasses or contact lenses	☐ Sinus infections	☐ Poor appetite
☐ Wears hearing aide	☐ Obstructive Sleep Apnea	☐ Hernia
☐ Head injuries	☐ Dental problems	☐ Eczema
☐ Frequent headaches	☐ Heart murmur	☐ Large birthmarks
☐ Seizures	☐ High blood pressure	☐ Multiple birthmarks
☐ Vocal or Motor Tics	☐ Thyroid problem	☐ Dislocation
☐ Frequent colds	☐ GERD (Reflux)	☐ Broken bones
☐ Asthma	☐ Stomach aches	☐ Scoliosis
☐ Seasonal allergies	☐ Constipation	☐ Flat feet
☐ Ear infections	☐ Diarrhea	☐ Bone pain
☐ Diabetes	☐ Weight changes	☐ Pain, location:_____

Surgeries, dates: _____ Reason: _____

Hospitalization, dates: _____ Reason: _____

Other: _____

DEVELOPMENTAL HISTORY

Speech Development

At what ages did your child do the following?

_____ Speak first words

_____ Several words besides "mama" and "dada" (1y)

_____ Have 5-7 additional words (18m)

_____ Speak in 2-3 word sentences (2y)

_____ Form long sentences

Can your child follow single – step directions? ☐ Yes ☐ No

Can your child follow multi-step directions? ☐ Yes ☐ No

Describe your child's current language skills: _____

Motor Development

At what ages did your child do the following?

_____ Roll (3-5m)

_____ Sit without support (5-7m)

_____ Crawl (6-8m)

_____ Walk (11-16m)

_____ Run (2y)

_____ Ride tricycle (3y)

_____ Ride bicycle (5-6y)

_____ Throw ball overhand (4y)

Any concerns about your child's motor skills? _____

Self-Help/Daily Living Skills

At what ages did your child do the following?

_____ Uses cup without help (1y)

_____ Use a spoon (1-2y)

_____ Use a fork (2-3y)

_____ Undress self (2 y)

_____ Dress self (3y)

_____ Unbutton (3y)

_____ Button (3y)

_____ Tie shoe laces (5y)

Any concerns about feeding/eating? Yes, Reason: _____ No ☐

At what age was your child toilet trained for:

Bowel Control Day time: _____ Night Time: _____ Not Yet ☐

Bladder Control Daytime: _____ Night Time: _____ Not Yet ☐

Social/Emotional Development

Describe your child's quality of attachment with…

Mother? _____ Father? _____

Does your child have difficulty getting along with…

Parents? ☐ Yes ☐ No Other children? ☐ Yes ☐ No

Siblings? ☐ Yes ☐ No

Does your child have a gender identity problem? ☐ Yes ☐ No

BEHAVIOR HISTORY

Describe your child's personality and general mood: _____

How many tantrums does your child have: _____ per day _____ per week

Does your child have aggressive behaviors (hitting, kicking, etc…)? Yes: _____ No ☐

What situations or scenarios usually cause your child to have a tantrum or act aggressively? _____

_____

What types of discipline strategies have you tried to address the above behaviors? _____

_____

Has your child's behavior changed or become worse? Yes: _____ No ☐

Does your child have a difficult time following house rules? Yes ☐ No ☐

Does your child have a problem with lying? Yes ☐ No ☐

Does your child have a problem with stealing? Yes ☐ No ☐

Does your child appear anxious or nervous often? Yes ☐ No ☐

Does your child have any fears or phobias? Yes: _____ No ☐

Does your child seem to have difficulty with concentration/focus? Yes ☐ No ☐

Does your child appear more active/impulsive than other children his/her age? Yes ☐ No ☐

Does your child have any unusual habits? Yes: _____ No ☐

My child **prefers** to play: alone ☐ with friends/family ☐ enjoys both ☐

Do you have concerns about how your child plays with others? Yes: _____ No ☐

SCHOOL HISTORY

Name of School: _____ Grade: _____

Describe Pre School Experience: _____

Does your child like school? ☐ Yes ☐ No, because _____

Does your child have problems with homework? ☐ Yes: _____ No ☐

Do you have concerns about your child's learning? ☐ Yes: _____ No ☐

What do teachers say about your child? _____

Please check any of the following interventions your child has received:

☐ 504 Accommodations	☐ RSP	☐ Counseling
☐ Student Study Team (SST)	☐ Speech Therapy	☐ Social Skills
☐ IEP	☐ Occupational Therapy	☐ Small Group Instruction
☐ Psychological evaluation	☐ Physical Therapy	☐ 1:1 aide
☐ Special Day Class	☐ Adapted P.E.	☐ Behavioral Support Plan

OTHER SERVICES

Is your child a client of the Regional Center: ☐ Yes, and receives: _____ No ☐

Is your child receiving therapy through California Children's Services (CCS)? ☐ Yes: _____ No ☐

Is your child receiving any therapies through medical insurance? ☐ Yes: _____ No ☐

Is your child receiving counseling? ☐ Yes: _____ No ☐

SLEEP HISTORY

What time do you put your child in bed? _____ pm

Does your child share a bedroom with other family members? Yes ☐ No ☐

Does your need another person in the room/bed to fall asleep? Yes ☐ No ☐

From the time you put your child in bed, how long does it take him/her to fall asleep? _____

What does your child do during this time? _____

Is there a TV in your child's bedroom? Yes ☐ No ☐

Is the TV on while child is in bed trying to fall asleep? Yes ☐ No ☐

In general, does your child sleep through the night? Yes ☐ No ☐

Does your child snore? Yes ☐ No ☐ Occasionally ☐

Please check any of the following problems your child has:

☐ Sleep walking
☐ Sleep talking
☐ Grinds teeth
☐ Nightmares/Night terrors
☐ Difficulty falling asleep
☐ Snorting/gasping for air
☐ Constant leg or body movements
☐ Other _____

Does your child take naps during the day? ☐ Yes, from _____ - _____ ☐ No

Does your child appear sleepy during that day as if they don't sleep well? Yes ☐ No ☐

FAMILY AND SOCIAL HISTORY

Check any of the following your child has been a victim or witness of:

☐ Sexual Abuse ☐ Neglect ☐ Physical Abuse

If yes to any of the above, please explain: _____

Please check any of the following family dynamics that apply:

☐ Parents are separated, date: _____
☐ Parents are divorced, date: _____
☐ Single Parent (other parent not involved)
☐ Adopted child
☐ Foster Care (past or present), date: _____
☐ DCFS Referral (past or present), dates: _____
☐ Death: _____
☐ Traumatic Event: _____
☐ Moves: _____
☐ Loss: _____

If parents are separated or divorced, what is the custody arrangement?

Physical custody: ☐ Joint ☐ Sole Which Parent: _____

Legal custody: ☐ Joint ☐ Sole Which Parent: _____

Visitation schedule/frequency: _____

Please list any individuals currently living in your home:

Name	Age	Relationship to patient	Health problems, if any

Family history of any of the following conditions (check all that apply. Include relationship to patient):

- ☐ Genetic condition: _____
- ☐ Birth defects: _____
- ☐ Blindness: _____
- ☐ Deafness: _____
- ☐ Intellectual Disability/Mental Retardation: _____
- ☐ Developmental Delays: _____
- ☐ Speech Delays: _____
- ☐ Learning problem: _____
- ☐ ADHD (Attention problem): _____
- ☐ Seizure Disorder: _____
- ☐ Depression: _____
- ☐ Bipolar Disorder: _____
- ☐ Anxiety Disorder: _____
- ☐ Schizophrenia: _____
- ☐ Systemic Lupus Disease: _____
- ☐ Arthritis: _____
- ☐ Thyroid Disease: _____
- ☐ Fibromyalgia: _____
- ☐ Migraines: _____
- ☐ Parkinson's/Tremors/movement disorders: _____
- ☐ Menopause starting at 40 years or earlier (50 is normal): _____
- ☐ Substance Abuse (Alcohol, drugs): _____
- ☐ Inter-family marriage (common ancestry): _____
- ☐ Other Medical Problem: _____

Birth Mother's History

Job: _____ Medical Problems: _____ Highest grade completed: _____

Received assistance in school: ☐ Yes, _____ ☐ No

Learning problem: ☐ Yes, _____ ☐ No

Behavior problem: ☐ Yes, _____ ☐ No

Childhood Atmosphere (abuse, illness, etc...): _____

Birth Father's History

Job: _____ Medical Problems: _____ Highest grade completed: _____

Received assistance in school: ☐ Yes, _____ ☐ No

Learning problem: ☐ Yes, _____ ☐ No

Behavior problem: ☐ Yes, _____ ☐ No

Childhood Atmosphere (abuse, illness, etc...): _____

Step, Foster, or Adoptive Mother's History (if applicable)

Job: _____ Medical Problems: _____ Highest grade completed: _____

Received assistance in school: ☐ Yes, _____ ☐ No

Learning problem: ☐ Yes, _____ ☐ No

Behavior problem: ☐ Yes, _____ ☐ No

Childhood Atmosphere (abuse, illness, etc...): _____

Step, Foster, or Adoptive Father's History (if applicable)

Job: _____ Medical Problems: _____ Highest grade completed: _____

Received assistance in school: ☐ Yes, _____ ☐ No

Learning problem: ☐ Yes, _____ ☐ No

Behavior problem: ☐ Yes, _____ ☐ No

Childhood Atmosphere (abuse, illness, etc...): _____

Is there anything else you would like me to know about your child?

SIGNATURE OF COMPLETION

_____ _____

Signature of Parent/Guardian who completed this form Date

To submit, download the completed form to your computer, save it and email.
Please include your name/patient's name in the subject line.

THANK YOU! WE LOOK FORWARD TO SERVING YOUR FAMILY.