OCEAN MEDICINE

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BNP PATIENT INTAKE FORM (6-21Y/O)

PATIENT INFORMATION

Child's Name: _____ Sex: _____ Date of birth: _____

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: _____

Mother's condition after delivery: _____

CHILD'S MEDICAL HISTORY

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

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

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

Last visit to Dentist: _____

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

DEVELOPMENTAL HISTORY

Speech Development

Did your child have delays in speech and language milestones? ☐ Yes ☐ No

Do you have any concerns regarding your child's communication skills now? ☐ Yes ☐ No

Did your child ever received Speech Therapy? ☐ Yes ☐ No

Motor Development

Did your child have delays in motor development milestones? ☐ Yes ☐ No

Do you have any concerns regarding your child's motor skills now? ☐ Yes ☐ No

Did your child ever physical therapy or occupational therapy? ☐ Yes ☐ No

Self-Help/Daily Living Skills

Does your child have any problems with self-help skills (toileting, feeding, bathing, etc.) ☐ Yes ☐ No

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 ☐ Grinds teeth ☐ Difficulty falling asleep

☐ Sleep talking ☐ Nightmares/Night Terrors

☐ Sleep apnea (snorting, gasping for air) ☐ Constant leg or body movements

☐ Other (Please Explain): _____

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: _____

Legal custody: ☐ Joint: _____ ☐ Sole: _____

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: _____
☐ Developmental Delays: _____
☐ Speech Delays: _____
☐ Learning problem: _____
☐ ADHD (Attention problem): _____
☐ Seizure Disorder: _____
☐ Depression: _____
☐ Bipolar Disorder: _____
☐ Anxiety Disorder: _____
☐ Schizophrenia: _____
☐ Systemic Lupus Disease: _____
☐ Arthritis: _____
☐ Deafness: _____
☐ Intellectual Disability/Mental Retardation: _____
☐ 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: _____ Highest grade completed: _____

Medical Problems: _____

Received assistance in school: ☐ Yes (Please Explain) _____ ☐ No

Learning problem: ☐ Yes (Please Explain) _____ ☐ No

Behavior problem: ☐ Yes (Please Explain) _____ ☐ No

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

Birth Father's History

Job: _____ Highest grade completed: _____

Medical Problems: _____

Received assistance in school: ☐ Yes (Please Explain) _____ ☐ No

Learning problem: ☐ Yes (Please Explain) _____ ☐ No

Behavior problem: ☐ Yes (Please Explain) _____ ☐ No

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

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

Job: _____ Highest grade completed: _____

Medical Problems: _____

Received assistance in school: ☐ Yes (Please Explain) _____ ☐ No

Learning problem: ☐ Yes (Please Explain) _____ ☐ No

Behavior problem: ☐ Yes (Please Explain) _____ ☐ No

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

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

Job: _____ Highest grade completed: _____

Medical Problems: _____

Received assistance in school: ☐ Yes (Please Explain) _____ ☐ No

Learning problem: ☐ Yes (Please Explain) _____ ☐ No

Behavior problem: ☐ Yes (Please Explain) _____ ☐ No

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

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