INFANT AND TODDLER DEVELOPMENT CLINIC

PATIENT HISTORY AND INTAKE FORM

Today's Date:_____

Child's Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Your Name ***(Last, First, M.I.):*** Your relationship to the child:	
What are your specific concerns about your child today?	
Email address:	**Phone number:**

CURRENT HEALTH CONCERNS

____ MY CHILD HAS NONE OF THE SYMPTOMS LISTED BELOW UNLESS CHECKED

PLACE A CHECKMARK NEXT TO ANY SYMPTOM OR CONDITION YOUR CHILD CURRENTLY HAS

Weakness/fatigue		Hoarse voice		Blood in stool	
Fever/chills		Trouble breathing		Difficulty gaining weight	
Sleep difficulties		Wheezing		Poor eating/drinking	
Seizures		Coughing		Easy bruising	
Trouble seeing/eye problems		Heart murmur		Yellow skin/jaundice	
Trouble hearing/ear problems		Vomiting		Rash/skin problems	
Trouble swallowing/chewing		Diarrhea			
		Constipation			

List your child's current medications, including over-the-counter medications, vitamins, supplements, inhalers, etc.

Name of Medication	Strength	Frequency

Is your child allergic to anything? (medicines, food, other)? ☐ No ☐ Yes If yes, please list:

Are your child's immunizations up to date? ☐ No ☐ Yes

Is your child receiving any therapies? (physical, occupational, speech) ☐ No ☐ Yes If yes, please list:

Is your child seeing any medical specialists besides the primary doctor:

If this is a follow up visit, please list any health or developmental issues or concerns that have occurred since last visit with us:

DEVELOPMENTAL SKILLS HISTORY

Let us know what your child can do now below: **Does your child…**

GROSS MOTOR	Yes/No
Roll over	
Hold head up steadily	
Sit alone	
Crawl	
Walks along furniture	
Walks alone	
Runs	
Walks up/down steps with hand held or holding wall or railing	

PROBLEM-SOLVING/FINE/VISUAL MOTOR	Yes/No
Tracks objects with eyes in all directions	
Reaches for toys	
Transfers toys from hand to hand	
Looks for dropped toys out of sight	
Releases objects into your hand or a container	
Uses thumb and fingers to pick up a tiny objects	
Scribbles	
Stacks blocks	
Puts shapes into a simple puzzle	
Put nesting cups together in the correct order	

SELF-HELP SKILLS	Yes/No
Holds bottle or cup	
Finger feeds self	
Holds spoon or fork and feeds self	
Pushes arms through sleeves	
Removes simple clothing (i.e. socks, shoes)	
Imitates simple household chores (i.e. clean-up, sweeping)	

SOCIAL-EMOTIONAL SKILLS	Yes/No
Smiles socially	
Recognizes difference between parents and strangers (stranger anxiety)	
Developed separation anxiety from parent	

LANGUAGE SKILLS	Yes/No
Participates in vocal turn-taking or back and forth sound play	
Plays interactive social games such as peek-a-boo	
Brings things to show you	
Waves bye-bye	
Uses a reaching gesture to communicate a desire	
Uses a definite finger point to indicate a want or need	
Uses a definite finger point to show you something and looks back to see if you are looking	
Follows a verbal direction coupled with a gesture	
Follows a verbal direction WITHOUT a gesture	
Says mama or dada	

DAILY ROUTINES

Eating-

Breastfeeding or formula- how many times per day and/or how many ounces per day:

Baby food- how much and how many times per day:

Table food-

Any coughing, choking or gagging with liquids or food?

Sleeping-

Does your child sleep through the night?

How many naps if any during day?

Elimination

How many wet diapers on average per day?

How often does child have a bowel movement? Any concerns with constipation or diarrhea?

Child Care

Does your child attend child care?

Thank you for your time!
The Infant Toddler Development Clinic Team