Neelam Kharod Sell, M.D.
Developmental–Behavioral Pediatrics

The Milestones Center
65 Mechanic Street, Suite L3
Red Bank, NJ 07701
1-732-345-8380
www.milestones.center

New Patient Intake Questionnaire

Today's Date: _____
Child's name: _____ Sex: M F
Date of birth: _____ Age: _____ years _____months

Race/Ethnicity: (please select all that apply)
- ▢ White ▢ Black or African American ▢ Native Hawaiian or other Pacific Islander
- ▢ Asian ▢ Hispanic or Latino ▢ American Indian or Alaska Native
- ▢ Other:

Primary language(s) spoken in home: _____
Would you like/need the services of an interpreter during your appointments? ☐ Yes ☐ No
Person completing this form: _____
Relationship to child: _____
Home #: _____Work #: _____ Cell #: _____
Best time to call: _____ Where? ☐ Home ☐ Work ☐ Cell
Child's Pediatrician: _____
Who referred you for an evaluation? _____
What are your concerns about your child?
- ▢ Language/speech ▢ Cognitive/learning development ▢ Emotional development ▢ Medical
- ▢ Motor development ▢ Behavior problems ▢ School performance

Please Explain: _____

At what age did you first become concerned? _____
What first caused you to be concerned?

_____

Has the child stopped developing and learning or lost any skills? ☐ Yes ☐ No
What questions do you have for the doctor about your child and what do you hope to accomplish during this evaluation?

_____

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Prenatal History

How old was mother when she became pregnant? _____
Was mother ever pregnant before this child? ▢ Yes ▢ No If yes, how many times? _____
When did the mother start prenatal care? _____
During the pregnancy, mother had:

- ▢ High blood pressure
- ▢ Smoked cigarettes (amount per day
- ▢ Used drugs/alcohol (amount per day)
- ▢ Mother took medications-(explain)
- ▢ Stress during pregnancy-(explain)
- ▢ Abnormal ultrasound-(explain)
- ▢ Abnormal tests during pregnancy-(explain)
- ▢ Other pregnancy problems-(explain)
- ▢ Diabetes
- ▢ Venereal disease
- ▢ Measles

Birth History

Is child ▢ adopted ▢ in foster care If so, from what age? _____
Baby's birth weight: _____lbs, _____oz.
Was the baby full term? ▢ Yes ▢ No If no, ▢early ▢late by _____ weeks
Type of delivery: ▢Vaginal ▢C-section
Any complications during the delivery? ▢ Yes ▢ No

Were there any of the following problems in the nursery?

- ▢ Was in NICU
- ▢ Breathing problems
- ▢ Low oxygen
- ▢ Infection
- ▢ Needed ventilator
- ▢ Feeding/sucking problems
- ▢ Intraventricular hemorrhage (bleeding in brain)
- ▢ Needed light therapy
- ▢ Apnea
- ▢ GER (reflux)
- ▢ Blood problems
- ▢ Jaundice
- ▢ Tube feedings

Where was the baby born? Monmouth Medical Center Riverview
Jersey Shore Centrastate Other: _____

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Review of Systems & Medical History

	Normal	Abnormal	Comments
Head, eyes, ears, nose, throat	▢	▢	_____
Vision Screening (date:_____)	▢	▢	_____
Hearing screening (date: _____)	▢	▢	_____
Heart	▢	▢	_____
Lungs	▢	▢	_____
Stomach/Intestinal/Constipation	▢	▢	_____
Skin	▢	▢	_____
Muscles/joints/bones	▢	▢	_____
Neurological (nervous system)	▢	▢	_____
Endocrine	▢	▢	_____
Environmental (exposure to smoke/toxins)	▢	▢	_____
Sleeping/Snoring	▢	▢	_____
Nutrition/Diet	▢	▢	_____

Is the child a picky eater? ▢ Yes ▢ No

Bowel Movements ▢ Formed ▢ Loose ▢ Diarrhea ▢ Constipated

Does your child have any allergies? ▢ Yes ▢ No Please explain: _____

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

Please list any medications your child is currently taking or had been taking on a regular basis (including vitamin supplements)
▢ None

Medication	Dose	Frequency

Has your child ever been hospitalized or required surgery? ▢ Yes ▢ No

_____

Does your child see any specialists? ▢ Yes ▢ No

_____

Have any of the following medical tests been done?

▢ Upper GI Series ▢ Endoscopy ▢ EEG ▢ Genetic (chromosome) testing
▢ Head CT scan ▢ Head MRI ▢ Other

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Developmental History

Has your child been diagnosed with any developmental conditions? ☐ Yes ☐ No

When did your child start doing the following?
(Please guess if exact ages are unknown or skip if you do not know)

Gross Motor:

Milestone	Age	N/A	Milestone	Age	N/A
Rolls over		☐	Climbs stairs (1 foot per step)		☐
Sits unsupported		☐	Run		☐
Crawls		☐	Pedal tricycle		☐
Pulls to a stand		☐	Hop		☐
Walks alone		☐	Climbs stairs (2 feet per step)		☐

Fine Motor/Adaptive:

Milestone	Age	N/A	Milestone	Age	N/A
Reach for objects		☐	Removes some clothes		☐
Pincer grasp		☐	Zippers, snaps & buttons		☐
Feeds self with fingers		☐	Hold cup		☐
Uses spoon (w/out help)		☐	Draws with crayons		☐
Shows hand preference		☐	Prints his/her name		☐
Right ( ) Left ( )					

Language:

Milestone	Age	N/A	Milestone	Age	N/A
Smile to others		☐	Understand "no"		☐
Laugh		☐	**Say first word**		☐
Babble		☐	**Point to desired object**		☐
Wave bye-bye		☐	**Loss of language**		☐
Say mama/dada		☐	Label objects		☐

Adaptive:

Toilet Trained:	Yes	No	Age		Yes	No	Age
Urine: Daytime	☐	☐		At night	☐	☐	
Stool: Daytime	☐	☐		At night	☐	☐	

Activity level of child:	☐	Normal	☐	High	☐	Low		
Mood:	☐	Happy	☐	Angry	☐	Depressed	☐	Negative
Sociability with other children:	☐	Ignores children	☐	Observes them	☐	Parallel play		
	☐	Initiates play	☐	Joins play	☐	Intrudes on play		

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What does your child like to do for play? _____

What are some of your child's strengths? _____

Behavioral History

Does your child have difficulty with any of the following (currently or past):

▢ Colic	▢ Irritability	▢ Sleeping
▢ Eating	▢ Eating non-food items	▢ Tantrums
▢ Head Banging	▢ Hitting self	▢ Hitting others
▢ Biting	▢ Impulsivity	▢ Hyperactivity
▢ Short attention span	▢ Forgetfulness	▢ Distractibility
▢ Difficulty completing tasks	▢ Lack of concentration	▢ Trouble with siblings
▢ Stealing	▢ Trouble with peers	▢ Fire Setting
▢ Fighting	▢ Destructiveness	▢ Masturbation
▢ Obsessions Compulsions	▢ Rituals	▢ Self-stimulation
▢ Unusual interests	▢ Need for sameness	▢ Fears
▢ Unusual body movements	▢ Anxiety	▢ Involvement with Law enforcement

Are problems more at: ▢ Home ▢ School ▢ other: _____

How do you deal with these behaviors?

▢ Ignoring	▢ Lecturing/Explaining	▢ Other _____
▢ Spanking	▢ Send child to his/her room	▢ Removal of privileges

Educational History

Does your child receive any of the following services?

Service		When did it start? How often per week or month?	Who provides services?
Occupational Therapy	▢ Yes ▢ No		
Physical Therapy	▢ Yes ▢ No		
Speech Therapy	▢ Yes ▢ No		
Behavioral Therapy	▢ Yes ▢ No		
Feeding therapy	▢ Yes ▢ No		
Early intervention/IU	▢ Yes ▢ No		
Other:	▢ Yes ▢ No		

Has your child received special education or other help in school? ▢ Yes ▢ No
Has your child ever repeated a grade? ▢ Yes ▢ No

Please list all schools or education programs your child has attended:

_____

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Family History

	Name	Age	Occupation
Child's Biological Father			
Child's Biological Mother			

Please list all biological children and any miscarriages:

Year	Outcome	Name	Sex	Present Age	Any developmental concerns
	□Living □Miscarriage				□ Yes □ No If yes, what?
	□Living □Miscarriage				□ Yes □ No If yes, what?
	□Living □Miscarriage				□ Yes □ No If yes, what?
	□Living □Miscarriage				□ Yes □ No If yes, what?

Is there anyone in the family with any of the following? (Tell us who in relation to the child has these conditions)

Condition	Father's Side	Mother's Side	Sibling	Detail/Treatment
ADD/ADHD				
Learning Disabilities				
Delayed Speech				
Need for Special Education				
Autism/PDD/Asperger's				
Birth Defects/genetic disorders				
Cerebral Palsy				
Seizures				
Depression				
Bipolar/Manic depressive				
Suicide				
Obsessive compulsive disorder				
Tics/Tourette's				
Excessive anxiety				
Medication for mental health				
Thyroid disorders				
Muscular Dystrophy				
Substance abuse				

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Social History

Who lives at home with the child? _____

Who takes care of child when not in school?

▢ Parent ▢ Grandparent ▢ Other Relative ▢ Daycare/childcare provider ▢ Other:

Is the child's life affected by any of the following? (Please check and explain all that apply):

- ▢ Separation/divorce, relationship problems _____
- ▢ Grief/loss issues _____
- ▢ Work/school problems _____
- ▢ Social skills or peer problems _____
- ▢ Quality or safety of home issues _____
- ▢ Physical challenges _____
- ▢ Recent changes in life circumstances _____
- ▢ Major life trauma (domestic violence/war/crime) _____

Religious preference? _____

Are there any special considerations that you or your child want us to be aware of related to your cultural, spiritual, or religious needs?

▢ Yes ▢ No If yes, explain: _____

Safety Screening

Do you think or know that the child has been physically abused?	▢ Yes	▢ No
Do you think or know that the child has been emotionally abused?	▢ Yes	▢ No
Do you think or know that the child has been sexually abused?	▢ Yes	▢ No
Are there any guns in the home?	▢ Yes	▢ No