THE VALLEY HOSPITAL
Paramus, New Jersey

Center for Child Development
Child Intake Questionnaire

Patient's Name: _____

DOB: _____

Reason for Visit

Patient/Parent/Caregiver Concerns: _____

_____

With which discipline is the patient scheduled? (Please circle all that apply):

Speech Therapy Feeding Therapy Physical Therapy Occupational Therapy Audiology

Patient Demographics

Address: _____

Parent/Guardian Name: _____

(1) Cell phone: _____ Home phone: _____ Email Address: _____

(2) Cell phone: _____ Home phone: _____ Email Address: _____

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer
☐ Other ☐ Choose not to disclose ☐ Unable to Obtain Option

Birth Sex: ☐ Male ☐ Female ☐ Unknown

Sexual Orientation: *The state has mandated that everyone be asked their sexual orientation regardless of age.*

☐ Straight or Heterosexual ☐ Lesbian ☐ Gay or Bisexual ☐ Other
☐ Don't know ☐ Unable to Obtain

Race: _____ Primary language: _____

Pediatrician: _____ Referring Provider (if different): _____

** **Please bring your prescription/referral to your initial appointment**

Do you currently see any of Valley's pediatric providers? ☐ Yes ☐ No

If yes, please circle all that apply: Audiology Psychiatry GI Endocrinology Neonatology
Neurology Developmental Pediatrician

Insurance

We strongly encourage you to call your insurance company and verify your financial responsibility. Visits at our center are billed as HOSPITAL OUTPATIENT VISITS and will be subject to your deductible. If you have further questions, the Kireker Center staff will be happy to help you. Please bring your insurance card and driver's license for registration.

Primary Insurance: _____

Secondary Insurance: _____

Guarantor (Holder of Insurance): _____ Guarantor's Date of Birth: _____

Relationship to Patient: _____ Occupation: _____

Guarantor's Address: _____

☐ Check if same as patient's address.

Guarantor's Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

Birth History

Weeks of pregnancy _____ Birth Weight _____

Hospital/Place of Birth: _____

Was your pregnancy high risk? ☐ Yes ☐ No

Any complications during pregnancy or delivery? ☐ Yes ☐ No ☐ Unknown

If Yes, _____

This pregnancy was:

☐ Spontaneous ☐ Achieved via assisted reproductive technology ☐ Twin ☐ Surrogacy

Type of Delivery:

Vaginal? ☐ Yes ☐ No

Planned C-Section? ☐ Yes ☐ No

Emergency C-Section? ☐ Yes ☐ No

Delivery Concerns:

☐ Breeched ☐ Vacuum ☐ Use of forceps ☐ Other _____

Were there any prenatal concerns? _____

Check all that apply:

☐ Asphyxia/lack of oxygen at birth/Assisted Ventilation
☐ Hyperbilirubinemia with exchange transfusion
☐ Jaundice
☐ Congenital or Perinatal Infection
☐ NICU If yes, length of stay _____
☐ ECMO (extracorporeal membrane oxygenation)
☐ Zika
☐ Other
☐ CMV (Cytomeglovirus)
☐ Well Baby Nursery
☐ Ototoxic Medications after birth (aminoglycosides: gentamicin, tobramycin, amikacin, streptomycin)

Center for Child Development
Child Intake Questionnaire

Medical History

Has your child had any surgeries or other hospitalizations? If yes, please list type and date.

☐ Surgeries _____

☐ Hospitalizations _____

Has your child had any imaging? If yes, please list type and date.

☐ MRI/CT _____ ☐ XRAY _____

☐ Other _____

Please check all that apply:

☐ Asthma
☐ Allergies
☐ Blood Pressure _____
☐ Cardiac Issues
☐ Cancer
☐ Dizziness/imbalance
☐ Headaches
☐ Muscle Tone Concerns _____
☐ Oxygen Dependence
☐ Pneumonia
☐ Respiratory Difficulties
☐ Serious Illness or Accidents
☐ Seizures
☐ Other _____

Current Medications (Prescribed or Over the Counter): _____

_____

_____

Developmental History

Has your child received any of the following diagnoses? Please check and provide date of diagnosis.

☐ ADHD _____
☐ Autism _____
☐ Developmental delay(s) _____
☐ Genetic disorder(s) _____
☐ Other _____

Has your child had any of the following evaluations? If yes, please provide report(s).

☐ Audiology ☐ Behavioral Assessment ☐ Early Intervention ☐ Feeding ☐ Vision Therapy
☐ Teacher of the Deaf ☐ Occupational therapy ☐ Physical therapy ☐ Speech/Language ☐ Other

Was your child recommended for any therapies? If yes, please include frequency.

_____

_____

_____

☐ Early Intervention Services:

Developmental Intervention_____

Speech Therapy_____

Physical Therapy_____

Occupational Therapy_____

☐ Private Therapy:

Applied Behavioral Analysis_____

Speech Therapy_____

Feeding Therapy_____

Physical Therapy_____

Occupational Therapy_____

Counseling Therapy_____

Other_____

Has your child been seen by other professionals or had additional evaluations? (e.g., Developmental Pediatrician, Orthopedist, Child Psychologist, etc.) ☐Yes ☐No

If yes, please describe: _____

_____

_____

_____

At what age did your child perform the following skills?

Roll back to belly: _____ Roll belly to back: _____

Sit unsupported: _____ Crawl: _____

Pull to stand: _____ Walk: _____

Drink from a cup: _____ Finger feed: _____

Babble (speech): _____ First words: _____

Combine words: _____ Use Sentences: _____

Additional Comments: _____

_____

Has the child completed vision screening? ☐Yes ☐No

Results: _____ Glasses: ☐Yes ☐No

Hand Preference: ☐Left ☐Right ☐Unknown _____

Center for Child Development
Child Intake Questionnaire

Behaviors and Characteristics: Please indicate if your child exhibits any of the following:

☐ Sensitive to loud sounds (covers ears)
☐ Short attention span
☐ Aversion to touch, taste, smell, light (if yes, please explain)_____
☐ Easily frustrated
☐ Difficulty following directions
☐ Impulsive
☐ Hyperactivity
☐ Disruptive
☐ Daydreams
☐ Tires easily
☐ Difficulty falling or staying asleep_____
☐ Difficulty socializing with same age peer
☐ Difficulty expressing ideas
☐ Forgetful
☐ Displays repetitive behaviors_____
☐ Difficulty hearing in noisy places
☐ Asks for repetition, says "huh?" or "what?"
☐ Spelling problems
☐ Dislikes school
☐ Frequent temper tantrums
☐ Fidgety/trouble sitting still
☐ Other_____

Social / Educational History

Patient lives with:

_____

Patient's school/daycare:_____ Grade:_____

List any Social/Academic Difficulties _____

_____

_____

Does your child receive any support or accommodations at school?

☐ 1:1 Aide ☐ 504 ☐ IEP ☐ Pull out for small group leaming. Reading ____ Math ____

☐ Other _____

Additional Information

Is this child legally adopted? ☐Yes ☐No Who is the legal guardian?_____

Is this child in foster care? ☐Yes ☐No Caseworker/Agency_____

Is there an open case with the Department of Child Protective Services ☐Yes ☐No

Is your child registered for PerformCare? ☐Yes ☐No

Center for Child Development
Child Intake Questionnaire

Are there any other things you would like to tell us about your child?

_____

_____

_____

_____

_____

_____

Feeding evaluations ONLY please complete the following:

Feeding History

Was feeding therapy recommended for your child? ☐ Yes ☐ No

Where: _____

When: _____

Problems during feeding:

☐ Choking ☐ Coughing ☐ Crying
☐ Nasal Regurgitation ☐ Vomiting ☐ Slow Feeding
☐ Reflux ☐ Gagging ☐ Food Refusal/Limited intake
☐ Other (please describe): _____

Food Allergies:

☐ None
☐ Unknown
☐ Milk protein allergy
☐ Other food allergies _____

Mealtime/Feeding Behaviors:

Position for feeding: _____

Utensils/bottles used: _____

Number of meals daily: _____

Amount taken at each meal: _____

Has your child maintained the growth curve for height and weight? ☐ Yes ☐ No

If no, _____

_____

Are you concerned about your child's bowel movements? ☐ Yes ☐ No

If Yes, _____

_____

Center for Child Development
Child Intake Questionnaire

In advance of your appointment please complete a diet log.

Please keep a 3-day diet log. If your child's feeding schedule changes from weekday to weekend (e.g.: daycare vs. home), please keep a 2-weekday diet log and a 2-weekend diet log. Please include the following information:

1. Time feeding began and time feeding ended
2. Food and drink provided and how much was consumed
3. Who was the feeder?
4. Observations of the feeder (e.g.: gagging, coughing, choking, vomiting etc.)

***On the day of the feeding evaluation, please bring a variety of preferred food and drink as well as a variety of items that are being refused. This will allow us to gain a holistic picture of your child's feeding and/or swallowing difficulties.**

Audiology evaluations ONLY please complete the following:

Audiological History

Do you have concerns about your child's hearing? ☐Yes ☐No

Check all that apply:

- ☐ Ear pain
- ☐ Ear infections (explain)_____
- ☐ Ear Tubes (explain) _____
- ☐ Pulls or tugs on ears
- ☐ Family history of permanent childhood hearing loss _____
- ☐ Other _____

Previous Hearing Test Completed (not including newborn or routine screening): ☐Yes ☐No

Where: _____

When: _____

Does your child wear hearing aids? ☐Yes ☐No

If yes, explain: _____

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Child Intake Questionnaire

Cancellation/Attendance Policy

Children cannot be left unattended in the waiting room. A parent/caregiver/designee must always remain in the center when the child is receiving services.

If you are unable to keep an appointment, please call 201-612-1006 in advance to cancel.

If two (2) consecutive appointments are missed without prior cancellation OR if 50% or more visits are missed in a two (2) month period, therapy will be discontinued.

We reserve the right to charge for No Shows. Be advised that your insurance company will not reimburse for any no show appointments.

Communication and Medical Record Requests

Communications via email will be encrypted in order to safeguard Protected Health Information ("PHI") unless the patient or personal representative requests otherwise.

The therapy plan of care will be sent to the referring physician. You can access the medical records by a formal request via the link below or without delay via the patient portal. The staff are not able to provide you with copies of medical records. More information regarding accessing the portal will be provided based on the patient's age.

All other medical record requests can be completed via this link:
https://www.valleyhealth.com/patients-visitors/health-information-management

Print Name Patient/Representative _____ Relationship _____

Patient/Representative Signature _____

Date: _____ Time: _____