THE VALLEY HOSPITAL
Ridgewood, New Jersey

Center for Child Development
Child Intake Questionnaire

Today's Date _____ **Child's Age** _____

Reason for Visit

Referring Diagnosis: _____

Patient/Parent/Caregiver Concerns: _____

_____

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

☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Audiology

Patient Demographics

Patient's Name: _____ DOB: _____

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

Does Birth Sex Match Gender Identity? ☐ Yes ☐ No ☐ Choose not to disclose

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

☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Other ☐ Don't know

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 list _____

_____

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: _____

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Birth History

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

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

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

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 ☐ CMV (Cytomeglovirus)

☐ Ototoxic Medications after birth (aminoglycosides: gentamicin, tobramycin, amikacin, streptomycin)

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_____

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Please check all that apply:

☐ Asthma
☐ Allergies
☐ Blood Pressure_____
☐ Cardiac Issues
☐ Cancer
☐ Dizziness/imbalance
☐ Headaches
☐ Muscle Tone Concerns _____
☐ Pneumonia
☐ 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)_____
☐ Fetal Alcohol Syndrome _____
☐ Other_____

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

☐ Audiology ☐ Behavioral Assessment ☐ Early Intervention

☐ Feeding ☐ Occupational therapy ☐ Physical therapy ☐ Speech/Language

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 Anyalysis_____ Speech Therapy_____ Feeding Therapy_____

Physical Therapy_____ Occupational Therapy_____ Counseling Therapy_____

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: _____

_____

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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: _____

Has the child completed vision screening? ☐ Yes ☐ No

Results: _____ Glasses use: ☐ Yes ☐ No

Hand Preference: ☐ Left ☐ Right ☐ Other _____

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 _____

_____

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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 learning. Reading____ Math ____

☐ Other _____

Additional Information

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

Is your child registered for PerformCare? ☐Yes ☐No

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

_____

_____

_____

_____

Feeding evaluations ONLY please complete the following:

Feeding History

Have you ever had a feeding evaluation completed before? ☐Yes ☐No

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:

☐ 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, _____

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.**

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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

When _____

Where _____

Does your child wear hearing aids ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

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: _____

Print Therapist Name: _____ Date: _____ Time: _____

Therapist Signature: _____