PEDIATRIC INTAKE QUESTIONNAIRE

Please fill out this form as completely as possible. This information will help us to better assess whether your child is a good candidate for the program.

Today's date (dd/mm/yyyy):		**Preferred language:**	
Person completing form:		**Relationship to patient:**	
PATIENT INFORMATION			
First name:		Last name:	
Date of birth (dd/mm/yyyy):	Age:	Sex: ☐ Male ☐ Female	
Permanent address:			
City:	State:	Country:	Zip code:
Home phone:	Cell phone:	Work phone:	Email:

PARENT(S) INFORMATION			
Mother's first name:		Mother's last name:	
Father's first name:		Father's last name:	
Other guardian first name:		Other guardian last name:	
Who is the patient's primary caretaker?	☐ Mother	☐ Father	☐ Other *(please specify):*

REFERRING PHYSICIAN INFORMATION			
First name:	Last name:	Specialty:	
Office address:			
City:	State:	Country:	Zip code:
Office phone no.:	Office fax no:	Email:	

INSURANCE INFORMATION		
☐ *Check here if patient is uninsured*		
Name of Insurance Provider:	Subscriber's name:	
Policy no. (ID):	Group no.:	
Insurance address:		
City:	State:	Zip code:
Phone no.:	Fax no:	

REASON FOR REFERRAL	
What is the reason you are applying to *The DISCOVER Program*? *Please check all that apply.*	
☐ Understand the cause of my child's illness	☐ Find treatment for my child's illness
☐ Learn about reproductive risks/options	☐ Understand the prognosis
☐ Other, *please describe:*	
What do you hope to get out of your visit with our clinical team?	

SUMMARY OF PRESENT ILLNESS/PRIMARY CONCERN			
What is your child's primary medical concern?			
Please list any additional medical diagnoses:			
1.	5.		
2.	6.		
3.	7.		
4.	8.		
At what age did you first note something wrong in your child?			
Over time, the clinical course of my child's illness has been:	☐ Stable	☐ Progressive	☐ Improving
Please describe:			

PREGNANCY HISTORY			
Were there any problems in the pregnancy? *Please check all that apply.*	☐ Yes	☐ No	☐ Unknown
☐ Bleeding	☐ Hospitalization	☐ Surgery	
☐ Diabetes	☐ Premature Labor	☐ Toxemia	
☐ High blood pressure	☐ Pre-eclampsia	☐ Other:	
☐ Infection(s), please specify:			
Were any medications or drugs used in the pregnancy? *Please check all that apply.*	☐ Yes	☐ No	☐ Unknown
☐ Alcohol *(amount):*	☐ Smoking *(amount):*		
☐ Prescription medication *(please specify):*	☐ Other drugs *(please specify):*		
☐ Prenatal Vitamins	☐ Folic Acid		
☐ Other:			
Were any tests or procedures done in the pregnancy? *Please check all that apply.*	☐ Yes	☐ No	☐ Unknown
☐ Amniocentesis, results:	☐ Maternal serum screening, results:		
☐ Carrier screening *(please specify):*	☐ Noninvasive Prenatal Testing (NIPT), results:		
☐ Chorionic villi sampling (CVS), results:	☐ Ultrasound, results:		
☐ Fetal MRI, results:	☐ Other:		
Delivery:			
Mother's age at delivery:	Length of pregnancy (weeks):		
Labor: ☐ Spontaneous ☐ Induced, *reason*:	Delivery: ☐ Vaginal ☐ C-section		
Were there any problems during the delivery?	☐ Yes	☐ No	☐ Unknown
Please describe:			

BIRTH HISTORY			
Weight:	Length:	Head circumference:	
Apgars scores if known:	Days spent in the hospital:		
Did your child spend time in the NICU (Neonatal intensive care unit)?		☐ Yes	☐ No
Please explain:			
Were there any medical concerns when the child was a newborn? *Please check all that apply.*		☐ Yes	☐ No
☐ Breathing problems	☐ Jaundice		
☐ Birth defect *(please specify)*:	☐ Low muscle tone		
☐ Feeding problems	☐ Other:		

DEVELOPMENTAL HISTORY				
Were you ever concerned about your child's development? *If yes, at what age?*			☐ Yes	☐ No
How old (in months) was your child when he/she began to:				
Smile:	Roll over:	Sit:	Crawl:	
Pull to stand:	Walk:	Use single words:	Make sentences:	
Is your child's speech delayed now?			☐ Yes	☐ No
Has your child lost any of the above skills?			☐ Yes	☐ No
Is your child in a special education program right now?			☐ Yes	☐ No
☐ Early Intervention	☐ Inclusion Program	☐ Special education classroom		
☐ Other:				
Does your child currently receive any special therapy? *Please check all that apply.*			☐ Yes	☐ No
☐ Speech *(times per week):*	☐ Occupational therapy *(times per week):*			
☐ Physical therapy *(times per week):*	☐ Other:			
Has your child ever had IQ testing? *If yes, please specify numerical results below.*			☐ Yes	☐ No
☐ Full scale IQ:	☐ Verbal IQ:	☐ Non-Verbal IQ:		
Do you have any concerns about your child's behavior? *Please check all that apply.*			☐ Yes	☐ No
☐ ADHD (Attention Deficit Hyperactivity Disorder)	☐ Autism Spectrum Disorder	☐ Obsessive Compulsive Disorder (OCD)		
☐ ADD (Attention Deficit Disorder)	☐ Bipolar Disorder	☐ PTSD		
☐ Anxiety	☐ Depression	☐ Self-stimulation		
☐ Aggressive	☐ Frequent tantrums	☐ Self-injury		
☐ Atypical sleeping pattern	☐ Hyperactive	☐ Schizophrenia		
☐ Atypical eating habits	☐ Other:			

MEDICAL HISTORY			
Does your child have any of the symptoms listed below? *Please check all that apply.*			
Skin:			☐ Yes ☐ No
☐ Inability to sweat	☐ Poor wound healing	☐ Unusual birthmarks	☐ Unusual hair
☐ Lumps or growths	☐ Rash	☐ Unusual nails	☐ Other:
Head:			☐ Yes ☐ No
☐ Brain malformation	☐ Hydrocephalus	☐ Seizures	☐ Spina bifida
☐ Dizziness	☐ Large head size	☐ Small head size	
☐ Headaches	☐ Other:		
Eyes:			☐ Yes ☐ No
☐ Aniridia	☐ Dislocated lenses	☐ Macular degeneration	☐ Retinal disease
☐ Blind	☐ Glaucoma	☐ Nystagmus	☐ Severe myopia
☐ Cataracts	☐ Lazy eye	☐ Poor night vision	☐ Other:
Ears:			☐ Yes ☐ No
☐ Chronic infections	☐ Pits/Tags	☐ Ringing in ears	☐ Unusual shape
☐ Missing ear(s)	☐ Conductive hearing loss	☐ Sensorineural hearing loss	☐ Other:
Mouth:			☐ Yes ☐ No
☐ Cavities	☐ Crowded teeth	☐ Large tongue	☐ Unusually shaped teeth
☐ Cleft lip or palate	☐ Extra teeth	☐ Missing teeth	☐ Other:
Endocrine:			☐ Yes ☐ No
☐ Diabetes	☐ Late puberty	☐ Thyroid problem	
☐ Early puberty	☐ Other:		
Growth:			☐ Yes ☐ No
☐ Failure to thrive	☐ Obesity	☐ Short stature	☐ Tall stature
☐ Other:			
Lungs:			☐ Yes ☐ No
☐ Asthma	☐ Bronchitis	☐ Pneumonia	☐ Shortness of breath
☐ Breathing problems	☐ Emphysema	☐ Other:	
Heart:			☐ Yes ☐ No
☐ Abnormal echocardiogram	☐ Cardiomyopathy	☐ Easily tired	☐ Mitral valve prolapse
☐ Aortic dilation	☐ Chest pains	☐ High blood pressure	☐ Passing out
☐ Arrhythmia	☐ Congenital heart disease	☐ Other:	
Blood:			☐ Yes ☐ No
☐ Anemia	☐ Hemophilia	☐ Low platelets	☐ Unexplained bruising
☐ Blood clots	☐ Leukemia	☐ Low white count	☐ Unexplained bleeding
☐ Cancer *(please specify):*		☐ Other:	

Stomach / Intestines:		☐ Yes	☐ No
☐ Abdominal pain	☐ Inflammatory bowel disease	☐ Tracheoesophageal atresia	
☐ Celiac disease	☐ Malrotation	☐ Trouble swallowing	
☐ Frequent constipation	☐ Polyps	☐ Ulcers	
☐ Frequent diarrhea	☐ Reflux	☐ Vomiting	
☐ Hirschprung disease	☐ Other:		
Bladder / Kidney:		☐ Yes	☐ No
☐ Frequent urination	☐ Reflux	☐ Urinary tract infections	
☐ Kidney stones	☐ Renal failure	☐ Other:	
Genitalia:		☐ Yes	☐ No
☐ Abnormal external appearance	☐ Absent ovaries	☐ Undescended testicles	
☐ Absent uterus	☐ Hypospadias	☐ Other:	
Muscles / Joints:		☐ Yes	☐ No
☐ Abnormal electromyelogram	☐ Hypotonia (low muscle tone)	☐ Muscle pain	
☐ Arthritis	☐ Increased joint flexibility	☐ Muscle wasting	
☐ Contractures	☐ Joint dislocations	☐ Poor coordination	
☐ Hypertonia *(increased muscle tone/spasticity)*	☐ Joint pain	☐ Other:	
Skeletal:		☐ Yes	☐ No
☐ Abnormal bone age	☐ Low bone density	☐ Pectus carinatum (pigeon chest)	
☐ Fractures without trauma	☐ Pectus excavatum (sunken chest)	☐ Scoliosis	
☐ Other:			
Hands and Feet:		☐ Yes	☐ No
☐ Extra fingers or toes	☐ Unusually shaped fingers	☐ Unusually shaped nails	
☐ Missing fingers or toes	☐ Unusually shaped toes	☐ Other:	

MEDICATIONS *(Current and Past)*		
Name	**Reason for taking**	**Currently taking?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

ALLERGIES *(Please list)*
1.
2.
3.
4.
5.

SURGERIES AND HOSPITALIZATIONS *(Please list)*		
Date (dd/mm/yyyy)	**Reason/Surgery**	**Hospital/Doctor**

SPECIALIST VISITS *Please list all doctors your child has seen, except primary care doctor and emergency room visits.*				
Type of specialist	**Date(s)** (dd/mm/yyyy)	**Doctor / Hospital**	**Reason for visit**	**Notes attached?**
Genetics				☐ Yes ☐ No
Cardiology (Heart doctor)				☐ Yes ☐ No
Endocrinology (Hormone doctor)				☐ Yes ☐ No
Neurology				☐ Yes ☐ No
Neurosurgery				☐ Yes ☐ No
Ophthalmology (Eye doctor)				☐ Yes ☐ No
Gastroenterology				☐ Yes ☐ No
ENT (Ear nose & throat doctor)				☐ Yes ☐ No
Pulmonologist (Lung doctor)				☐ Yes ☐ No
Nephrologist (Kidney doctor)				☐ Yes ☐ No
Orthopedist (Bone doctor)				☐ Yes ☐ No
Developmental Pediatrician				☐ Yes ☐ No
Psychiatrist / Psychologist				☐ Yes ☐ No
Other *(please specify):*				☐ Yes ☐ No
Other *(please specify):*				☐ Yes ☐ No

LABORATORY TESTS AND IMAGING STUDIES				
Test / Study	**Date(s)** (dd/mm/yyyy)	**Doctor / Hospital**	**Results if known**	**Results attached?**
Brain MRI or Head CT				☐ Yes ☐ No
EEG				☐ Yes ☐ No
Hearing Test				☐ Yes ☐ No
Echo or EKG				☐ Yes ☐ No
X-ray (indicate of what):				☐ Yes ☐ No
Ultrasound (indicate of what):				☐ Yes ☐ No
Other, please specify:				☐ Yes ☐ No
Genetic Testing *Please check all that apply.*				
☐ Chromosome Analysis (karyotype)				☐ Yes ☐ No
☐ Chromosomal Microarray				☐ Yes ☐ No
☐ Single gene sequencing (specify genes)				☐ Yes ☐ No
☐ Whole Exome sequencing				☐ Yes ☐ No
Other, please specify:				☐ Yes ☐ No
Metabolic Labs *Please check all that apply.*				
☐ Organic Acids (urine)				☐ Yes ☐ No
☐ Amino Acids (blood)				☐ Yes ☐ No
☐ Acylcarnitine				☐ Yes ☐ No
Other, please specify:				☐ Yes ☐ No
Other Laboratory Results:				
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

FAMILY HISTORY					
Is the child adopted? *If yes, please answer the family history information to the best of your knowledge.*				☐ Yes	☐ No
Is the child's mother alive?				☐ Yes	☐ No
If No,	Age of death:	Cause of death:			
Please list any health problems in the mother:					
What is the mother's ancestry? *Please check all that apply*					
☐ Caucasian	☐ African American	☐ Asian	☐ Native American	☐ Hispanic	
☐ Jewish	☐ Unknown	☐ Other:			
Has the child's mother had any pregnancy losses (miscarriage)?				☐ Yes	☐ No
If yes, please list number and reason(s):					
Is the child's father alive?				☐ Yes	☐ No
If No,	Age of death:	Cause of death:			
Please list any health problems in the father:					
What is the father's ancestry? *Please check all that apply.*					
☐ Caucasian	☐ African American	☐ Asian	☐ Native American	☐ Hispanic	
☐ Jewish	☐ Unknown	☐ Other:			
Are the child's parents related to each other?				☐ Yes	☐ No
If yes, please indicate relationship (first cousins, second cousins, etc.):					
Does the child have any FULL brothers and sisters? (i.e. same mother and father) *If sibling is deceased, please write age of death as "d. 14yr" and record cause of death in health problems section.*				☐ Yes	☐ No
Name		**Age**	**Healthy?**	**Health problems**	
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
Does the child have any HALF brothers and sisters from his/her mother? *If sibling is deceased, please write age of death as "d. 14yr" and record cause of death in health problems section.*				☐ Yes	☐ No
Name		**Age**	**Healthy?**	**Health problems**	
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
Does the child have any HALF brothers and sisters from his/her father? *If sibling is deceased, please write age of death as "d. 14yr" and record cause of death in health problems section.*				☐ Yes	☐ No
Name		**Age**	**Healthy?**	**Health problems**	
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		

Please list any family members (living or deceased) with similar problems or symptoms as your child: *If family member is deceased, please write age of death as "d. 14yr" and record cause of death in health problems section.*			
Name		**Relationship**	**Health problems**
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		
	☐ Male ☐ Female		

To the best of your knowledge does your child have any relatives with the following problems? *If yes, please check box and indicate relationship to child (i.e. cousin, aunt, grandparent, etc.).*	☐ Yes	☐ No

☐ Anencephaly:	☐ Learning issues:
☐ Anemia:	☐ Limb defects:
☐ Arthritis:	☐ Mental retardation:
☐ Autism spectrum disorder:	☐ Mental illness:
☐ Birth defect:	☐ Metabolic problem:
☐ Blindness or eye disorder:	☐ Muscular dystrophy:
☐ Bone disorder:	☐ Multiple miscarriages:
☐ Cancer:	☐ Neurofibromatosis:
☐ Chromosome abnormality:	☐ Neurologic disorder:
☐ Cleft lip/palate:	☐ Seizures:
☐ Clots (blood):	☐ Short stature (< 5'0"):
☐ Cystic fibrosis:	☐ Skeletal abnormality:
☐ Deafness:	☐ Skin disease:
☐ Heart defect:	☐ Spinal muscular atrophy:
☐ Hemophilia:	☐ Spina bifida:
☐ Huntington disease:	☐ Strokes:
☐ Hydrocephalus:	☐ Tall stature (> 6'0"):
☐ High blood pressure:	☐ Urinary tract abnormality:
☐ Infertile:	☐ Mental retardation:
☐ Intellectual disability:	☐ Mental illness:
☐ Kidney disease:	☐ Other:

Please add any additional information that you think would be helpful in our evaluation of your child: