ADULT INTAKE QUESTIONNAIRE

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

Today's date (dd/mm/yyyy):	**Preferred language:**

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:

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 you are 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 illness	☐ Find treatment for my 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 primary medical concern?			
Please list any additional medical diagnoses:			
1.	5.		
2.	6.		
3.	7.		
4.	8.		
When did you first begin noticing symptoms of your illness?			
Over time, the clinical course of my illness has been:	☐ Stable	☐ Progressive	☐ Improving
Please describe:			

SOCIAL HISTORY			
What is the highest level of education you completed?			
☐ Middle school	☐ High school	☐ GED	☐ College
☐ Graduate degree	☐ Other:		
Were you ever diagnosed with a learning disability or other learning problems?		☐ Yes	☐ No
If yes, please specify:			
Did you receive any additional learning resources or therapies? *Please check all that apply.*		☐ Yes	☐ No
☐ Special education	☐ Speech therapy	☐ Occupational therapy	
☐ Physical therapy	☐ Other:		
What is your job or profession?			
Are you retired?		☐ Yes	☐ No
Are you on disability?		☐ Yes	☐ No
Have you ever been diagnosed with a behavioral or mental health condition? *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:		
Do you have any history of smoking?		☐ Yes	☐ No
☐ Previously, amount:	☐ Active, amount:		
Do you drink alcohol?		☐ Yes	☐ No
How many drinks per week?			
Do you have any history of drug use?		☐ Yes	☐ No
☐ Previously, amount:	☐ Active, amount:		

MEDICAL HISTORY			
Do you 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:
Neurological:			☐ Yes ☐ No
☐ Balance Problems	☐ Dizziness	☐ Loss of coordination	☐ Speech problems
☐ Brain malformation	☐ Headaches	☐ Seizures	☐ Unusual head shape
☐ Decreased feeling in hands/feet/arms/legs	☐ Large head size	☐ Small head size	☐ 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
☐ Hyperthyroid	☐ Polycystic ovarian syndrome	☐ Type II Diabetes	
☐ Hypothyroid	☐ Short staure (<5'0)	☐ Unexplained weight gain	
☐ Infertility	☐ Tall stature (>6'0)	☐ Unexplained weight loss	
☐ Obesity	☐ Type I Diabetes	☐ 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 you have 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					
Are you adopted? *If yes, please answer the family history information to the best of your knowledge.*				☐ Yes	☐ No
Is your mother alive?				☐ Yes	☐ No
If No,	Age of death:	Cause of death:			
Please list any health problems in your mother:					
What is your mother's ancestry? *Please check all that apply*					
☐ Caucasian	☐ African American	☐ Asian	☐ Native American	☐ Hispanic	
☐ Jewish	☐ Unknown	☐ Other:			
Has your mother had any pregnancy losses (miscarriage)?				☐ Yes	☐ No
If yes, please list number and reason(s):					
Is your father alive?				☐ Yes	☐ No
If No,	Age of death:	Cause of death:			
Please list any health problems in your father:					
What is your father's ancestry? *Please check all that apply.*					
☐ Caucasian	☐ African American	☐ Asian	☐ Native American	☐ Hispanic	
☐ Jewish	☐ Unknown	☐ Other:			
Are your parents related to each other?				☐ Yes	☐ No
If yes, please indicate relationship (first cousins, second cousins, etc.):					
Do you have any biological children? *If child 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	
	☐ Male ☐ Female		☐ Yes ☐ No	
	☐ Male ☐ Female		☐ Yes ☐ No	
	☐ Male ☐ Female		☐ Yes ☐ No	

Have you ever experienced a miscarriage (pregnancy loss)? *If yes, please list each miscarriage below.*	☐ N/A	☐ Yes	☐ No

Length of pregnancy	Reason for miscarriage
weeks	☐Unknown ☐Known, please specify:
weeks	☐Unknown ☐Known, please specify:
weeks	☐Unknown ☐Known, please specify:

Have you ever terminated a pregnancy?	☐ Yes	☐ No
If yes, what was the reason?		

Do you have any FULL siblings? (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	
Do you have any HALF siblings from your 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	
Do you have any HALF siblings from your 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) who have medical issues that are similar to yours: *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 do you have any relatives with the following problems? *If yes, please check box and indicate relationship (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: