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| *North Carolina Infant-Toddler Program* |  |

## *Intake / Child History Form*

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| **Child’s Name:** | |  | | | | | | | | | | |  | **Date of Birth:** | | | | | | | |  | | |
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| **I. Medical Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Were there any complications during pregnancy? Check all that apply: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Infection | | | | |  | | Rh incompatibility | | | | | | |  | | Chronic Disease | | | | | | | |
|  | Vaginal Bleeding | | | | |  | | High Blood Pressure | | | | | | |  | | Injury or accident | | | | | | | |
|  | Toxemia | | | | |  | |  | | | | | | |  | |  | | | | | | | |
| 1. Was your child born prematurely?  No  Yes If yes, gestational age: | | | | | | | | | | | | | | | |  | | | | | | |  | |
| 1. How was your baby delivered?  Vaginally  Cesarean Section (c-section) | | | | | | | | | | | | | | | | | |  | |  | | | | |
| 1. What was your child’s weight at birth? | | | | | | | | | |  | |  | | | | | | | | | | | | |
| 1. Did your child have any problems after birth (for example, respiratory distress, congenital anomalies, brain trauma, etc? | | | | | | | | | | | | | | | | | | | | | | | | |
| No  Yes If yes, explain: | | | | | | | | |  | | | | | | | | | | | | | | | |
| 1. Hospital where child was born: | | | | | | | | |  | | | | | | | | | | | | | | | |
| 1. Does your child have any current medical problems?  No  Yes If yes, what? | | | | | | | | | | | | | | | | | | | | | | | | |
| Hearing:   1. Do you have any concerns about your child’s hearing?  No  Yes If yes, what? 2. Did your child pass the newborn hearing screen?  No  Yes   Vision:   1. Do you have concerns about your child’s vision?  No  Yes If yes, what? | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Is your child currently taking any medication?  No  Yes If yes, what? | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Is your child allergic to any foods or medications?  No  Yes If yes, please list. | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Are your child’s immunizations up to date?  No  Yes  Not Sure | | | | | | | | | | | | | | | | | | | | | | | | |
| List your primary physician and indicate if your child has ever seen any specialists such as an ophthalmologist, ear/nose and throat doctor, or neurologist. | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | **Address** | | | | | | | | | | | **Reason Seen / Outcome** | | | | | | | | |
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| **II. Developmental History** | | | | | | | | | | | | | | | | | | | | | | | | |
| At what age did your child first: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | **Age** | | | | | | |  | | | | | | | | | | | | | **Age** |
| Roll over | | | |  | | | | | | | Say single words | | | | | | | | | | | | |  |
| Sit alone | | | |  | | | | | | | Use 2- or 3-word combinations | | | | | | | | | | | | |  |
| Crawl | | | |  | | | | | | | Exchange expressions with you (smile) | | | | | | | | | | | | |  |
| Walk alone | | | |  | | | | | | | Responds to own name | | | | | | | | | | | | |  |
| Feed self (fingers / utensil) | | | |  | | | | | | | Lets you know what he/she wants and doesn’t want | | | | | | | | | | | | |  |
| Additional pertinent information: | | | | | | |  | | | | | | | | | | | | | | | | | |
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| CDSA staff person collecting information from family | | |  | | | | | | | | | | | | | | | |  | |  | | | |
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|  | | | Name/Title | | | | | | | | | | | | | | | |  | | Date | | | |