TuftsMedicine
Pediatrics

Division of Developmental-Behavioral Pediatrics
800 Washington St., Box 334
Boston, MA 02111

TUFTS MEDICINE PEDIATRICS

Parent intake questionnaire

Instructions:
Fill out the form to the best of your ability. When complete, email to: **ccsnforms@tuftsmedicine.org.**

Our system cannot read photos. Please send via PDF. If you prefer regular mail, please send it to our address listed above.

We are looking forward to meeting you and your child!

Demographic information

CHILD

First name _____ Last name _____ Date of birth _____

Today's date _____ Street address _____ City _____ State _____ Zip Code _____

PARENT/GUARDIAN #1

First name _____ Last name _____ Date of birth _____

Street address _____ City _____ State _____ Zip Code _____

Primary phone number _____ Secondary phone number _____ Email address _____

Primary language _____ **Y / N** Interpreter needed

PARENT/GUARDIAN #2

First name _____ Last name _____ Date of birth _____

Street address _____ City _____ State _____ Zip Code _____

Primary phone number _____ Secondary phone number _____ Email address _____

Primary language _____ **Y / N** Interpreter needed

12244 0626

What are your concerns? How can we help you?

Prenatal + birth history

Age of parents at time of pregnancy

Illnesses or other concerns during pregnancy **Y / N**

Medications taken during pregnancy **Y / N**

Exposures during pregnancy, such as alcohol, nicotine, marijuana, narcotics, cocaine or others **Y / N**

Birth/Delivery

Gestational age at birth (weeks)

Child's birthweight

Vaginal delivery **Y / N**

C-section delivery **Y / N**

Complications at delivery **Y / N**

Neonatal period

Special care or intensive care needed **Y / N**

Concerns during the first four weeks **Y / N**

Child's past + current medical history:

Current medications **Y / N** _____

Current allergies **Y / N** _____

Medical conditions **Y / N** _____

Specialists **Y / N** _____

Are there any medical doctors who care for your child besides your child's primary care provider?

Hospitalizations **Y / N** _____

Surgeries **Y / N** _____

Hearing problems **Y / N** _____

Vision problems **Y / N** _____

Respiratory problems **Y / N** _____

Heart problems **Y / N** _____

GI problems **Y / N** _____

Neurological problems **Y / N** _____

Child's past + current developmental/behavioral health conditions:

Behavioral health problems **Y / N**

_____

ex: anxiety, depression, trauma, attachment problems

Developmental problems **Y / N**

_____

ex: learning disability, ADHD, Autism, language impairment, disruptive behaviors, motor delays

Family medical history:

DEVELOPMENTAL CONDITIONS **Y / N**

Please identify which family member has autism spectrum disorder, ADHD, intellectual disability, learning disability, speech and language delays, developmental delays, etc.

MENTAL HEALTH CONDITIONS **Y / N**

Please identify which family member has anxiety, depression, bipolar disorder, OCD, substance use issues, etc.

MEDICAL CONDITIONS **Y / N**

Please identify which family member has chronic medical conditions: cardiac issues, genetic disorders, etc.

Provide additional information here if needed:

Social context:

Who lives at home with your child?

Has your child experienced any difficult or scary life events?

ex: separation from parents, death of loved one, seeing something scary, moves, etc.

How do you and your family get through hard times?

Who are the other adults who care about you and your child?

Thank you so much for completing this form. We look forward to meeting you and your child.