KIDSPACE Adaptive Play and Wellness
469 Buckland Road, Suite 102
South Windsor, CT 06074

INFANT through 5 YEARS OLD
Intake Questionnaire

Today's Date: _____ /_____ /_____

Name: _____

Date of Birth: _____ /_____ /_____ Age: _____ Gender: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Family Status: _____

Parent/Guardian 1: _____

Preferred Phone: (_____)_____-_____ Occupation:_____

Email Address: _____

Parent/Guardian 2: _____

Preferred Phone: (_____)_____-_____Occupation:_____

Email Address: _____

With whom and how should we be in touch regarding your child's care?

Parent/Guardian_____Text/Call/Email_____

Whom may we thank for referring you to KIDSPACE _____

MEDICAL PROVIDERS and CONSENT TO SHARE RECORDS

List the names of your medical providers. Check the appropriate box to indicate whether or not you would like us to share records.

Pediatrician_____ ☐ **Yes** ☐ **No**

Midwife/OB_____ ☐ **Yes** ☐ **No**

Lactation Consultant_____ ☐ **Yes** ☐ **No**

Dentist_____ ☐ **Yes** ☐ **No**

Other_____ ☐ **Yes** ☐ **No**

Parent/Guardian 1 Signature: _____

Parent/Guardian 2 Signature: _____

CURRENT CONCERNS

Please list your concerns about your child in order of importance:

1. _____
2. _____
3. _____
4. _____

What are his/her current symptoms: _____

When did they begin? _____

How did they begin? _____

Has he/she had any treatment for these symptoms? _____

What are you goals for your child's care at KIDSPACE?

_____

Describe your child in your own words:_____

PREGNANCY and DELIVERY

Mom's age when baby was born?_____ How many pregnancies? _____Live births? _____

Any problems conceiving?_____Treatment?_____

How was pregnancy overall?_____

During pregnancy was mom on medication (over the counter/prescribed/recreational)?

_____

During pregnancy did mom smoke or consume any alcoholic beverages? _____

Was mom in pain during pregnancy?_____

Was mom physically ill? (colds, flu, allergies, German measles, etc.)_____

Was labor chemically induced?_____ Doctor assisted?_____

Approximately how long was labor?_____ Who was present?_____

C-section?_____ Were forceps/vacuum used?_____

Did doctor have hands on the child?_____ What position was mom in?_____

Any time in NICU?_____ Why?_____ How long?_____

What was baby's gestational age?_____ Length?_____ Weight?_____ Head circumference?_____

Baby's APGARS:_____1 min_____5 min; Any problems at birth?_____

Did mom breastfeed?_____ Any problems?_____ How long?_____

Did mom bottle-feed?_____ What formula?_____ Any problems?_____

Did mom see a lactation consultant in hospital?_____ Who?_____

Did mom see a lactation consultant privately?_____ Who?_____

Are mom and baby currently working with a lactation consultant?_____ Who?_____

MEDICAL HISTORY

Birth weight _____ Loss from birth weight _____ Time to return to birth weight _____

Current weight _____ Where _____ When _____ ☐ Nude ☐ With Diaper ☐ Clothed

How many wet diapers/day? _____ How many stools/day? _____

Color, texture, smell, seeds of the stool? _____

Any mucous or blood in the stool? _____

Is baby exclusively fed at the breast or are you supplementing? _____

Supplementation: bottle_____SNS_____fingerfed_____other_____

- Pumped breast milk (your own):_____# of oz_____
- Formula (type) _____# of oz_____
- Donated breast milk _____# of oz_____

How many times is the baby at breast and how many times is the baby supplemented as noted above?

_____

What brand of bottle do you use? _____

Does baby use a pacifier? If so, how often?_____

Please describe any major illnesses, previous diagnoses, hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.:

Date	Description

Please list any known allergies (drugs, food, environmental, chemical, etc) and the reactions to them:

_____

Please list any and all current medications (prescription and over-the counter) & supplements (vitamins, herbs, homeopathic remedies):

Name of Drug/Supplement	Date Started	Dosage/Frequency	Prescribed for

Does your child have any of the following?

_____Apnea _____Colic _____Constipation

_____Congestion _____Diarrhea _____Difficulty Breathing

_____Ear Infections _____Irritability _____Rashes

_____Snoring _____Other

Please describe your child's habits as good, fair or poor:

Bowel_____ Eating_____ Listening_____

Mood_____ Sleeping_____ Physical Strength_____

Has your child had any of the following illnesses?

_____Measles _____German Measles _____Mumps

_____Pneumonia _____Scarlet Fever _____Chicken Pox

_____Cancer _____Rheumatic Fever _____Urinary Tract Infection

_____RSV _____Rotavirus _____Strep Throat

_____HIV/AIDS _____Tuberculosis _____Other Illnesses

PLEASE COMPLETE IF THE CHILD IN QUESTION IS CURRENTLY BREASTFEEDING
Check or fill in the blank for each item that applies to you and your child:

_____Unable to latch onto the breast at all

_____Unable to latch onto the breast well

_____Long breastfeeding times (How long?_____)

_____Frequent breaks in feeding

_____Falling asleep at the breast

_____Baby has difficulty sleeping and wakes frequently to feed

_____Nursing at night (how many times?)

_____Thrusting tongue

_____Nursing on tip of nipple only

_____Nursing constantly

_____Combative nursing (arching backward, pushing off)

_____Difficulty opening wide

_____Clamping/Biting nipple

_____Upper lip does not flare out

_____Lips look chapped/cobble stone appearance

_____Excessive gas, burp, wind, hiccups – (circle all that apply)

_____Milk leaks out of the mouth

_____Choking on milk

_____Clicking noise during feed

_____Unable to stick the tongue out past the gum

_____Unable to stick the tongue out past the lower lip

_____Reduced elevation of the tongue (can the tongue lift up and touch the roof of the mouth)

_____Heart shaped tongue when baby lifts tongue or sticks tongue out (elevation & extension)

_____Sweeping your finger under the tongue reveals a “speed bump” or obstruction

_____Heredity: history of lip tie or tongue tie Siblings _____ Parents _____ Grandparents _____

_____Failure to gain weight or slow to gain weight

Any additional information:_____

Are you eating and drinking sufficiently to feed two of you?_____

Are you are dealing with inflammatory health issues?_____

Do you have a history of breast surgery (reduction or augmentation), breast cancer, poor ductal development?

_____

Did you breasts increase 1 to 2 sizes during pregnancy?_____

How many children have you breastfed?_____

When did your milk come in with this child?_____

How is your milk supply?_____

How is your milk ejection reflex (let down)?_____

Are you using herbs or medicine to augment your milk supply?_____

Are you using herbs or medicine to reduce your milk supply?_____

Are your nipples painful?_____

Are they damaged? _____

Are you using a nipple shield or SNS?_____

Do you have plugged ducts (or have you had mastitis)?_____

Are you applying anything topically to your breasts?_____

Do your breasts ever feel full?_____

Does your baby empty your breasts?_____

Are you pumping at this time?_____

How frequently do you pump?_____For how long (1 or 2 breasts at a time?)_____

Are you pumping to feed your baby or store milk?_____

When do you return to work?_____

Are you anticipating ending breastfeeding or adjusting baby’s schedule to your own?_____

MATERNAL HISTORY

Did you receive antibiotics during pregnancy, labor and delivery or in the post-partum period)?_____

Please list all current medications, supplements, herbs, homeopathy:

_____

Are you drinking alcohol, smoking, taking any caffeine, or recreational drugs? If so, how much and how often?

_____

Do you have any sign of a yeast infection? (vaginal discharge, odor, red patches on skin, itchy areas on skin, gas and bloating, foggy thinking, etc.)_____

How was your postpartum healing experience?_____

Did you or are you suffering from postpartum depression?_____

Did you or are you now suffering from thyroid dysfunction?_____

Do you have support at home or are you on your own?_____

Are you stressed?_____

Are you sleeping?_____How much and how often?_____

What is your nutrition like?_____

Do you have any foods you eliminate due to sensitivity or allergy? _____

Do you have any other significant medical conditions (issues with heart or lung, history of cancer) or history of injury, surgery, past chiropractic care?_____

FAMILY MEDICAL HISTORY Please specify maternal vs paternal grandparents.

	Mother	Father	Brothers	Sisters	Maternal/Paternal Grandparents
Check if applicable					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Mental Illness					
Asthma					
Kidney Disease					
Autoimmune Disease					
Other					

DEVELOPMENTAL INFORMATION

Is your child currently meeting age-appropriate developmental milestones? _____

If you're unsure, please indicate when they met the milestones below:

0-3 MONTHS

- Holds head up _____
- Tolerates tummy time _____

3- 12 MONTHS

- Rolls over _____
- Crawls_____
- Sits up _____
- Pulls up to stand_____
- Cruises_____
- Puts object in container_____
- Babbles_____

12-18 MONTHS

- Stands unsupported, sits down_____
- Bends and recovers balance_____
- Builds tower 5 blocks_____
- Says 10 words_____
- Eats with a fork and spoon _____

2 ½ - 4 YEARS

- Plays with other children_____
- Walks up and downstairs (one foot per step) _____
- Climbs on play equipment_____
- Dresses themselves_____
- Potty trained_____
- Stands on one foot_____
- Speech is 75% intelligible_____

4-5 YEARS

- Hops on one foot_____
- Runs in a coordinated manner_____
- Gallops and begins to skip_____
- Rides a bicycle or tricycle_____

IMMUNIZATION RECORD

Please record the date of each immunization given to your child.

Vaccine	Date Given (m/d/yy)	Vaccine	Date Given (m/d/yy)
Hepatitis B		**Hepatitis A**	
Diptheria, Tetanus, Pertussis		**Meningococcal**	
		Human papillomavirus	
		Zoster (shingles)	
boosters			
		Influenza (yearly)	
***Haemophilus influenzae* type b**			
Pneumococcal			
		Other	
Polio			
Rotavirus			
Measles, Mumps, & Rubella			
Varicella (chickenpox)			

Is your child up to date on all immunizations? ☐ Yes ☐ No

Please list any adverse reactions to immunizations. Please be specific.

_____

_____

Were these reactions reported to VAERS? ☐ Yes ☐ No

CONSENT FOR TREATMENT OF A MINOR

We, the parents or guardians, consent to the treatment/procedure rendered to our child or ward under general and specific instructions of my child's health care provider including but not limited to chiropractic, CranioSacral therapy, massage, sensory processing, or recreational therapy, as well as nutritional, homeopathic and herbal therapies and whole health counseling. We have had the mechanisms and risks of chiropractic adjustments based on pediatric anatomy and physiology explained to our satisfaction and authorize said treatment on the above-named child understanding the risks and incidence of deleterious effect. We recognize that even the gentlest therapies may potentially have complications in very young children or in those on multiple medications. Hence, the information we have provided our health care providers is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs our child may be taking. With this knowledge, we voluntarily consent to the proposed procedures. We acknowledge that no guarantees of cure or improvement of condition have been made. We understand that we are free to withdraw consent and to discontinue treatment at any time. We attest that we are the legal parent(s)/guardian(s) and are designated and authorized to make healthcare decisions and consent to healthcare for this child.

Our practice is collaborative in nature. We often consult with each other and co-manage in order to best serve our patients.

You are responsible for informing our providers of any relevant information or changes that affect your child's health. Should privileged information be shared via text message or email, your provider will make every effort to maintain privacy but text messaging and emailing are not encrypted or HIPAA-approved means of communication.

_____

Parent/Guardian Signature 1 Date

_____

Parent/Guardian Signature 2 Date

CONSENT TO PHOTOGRAPH

Photographs of your child help us see changes and help us teach other health care providers about caring for children with similar problems. Due to HIPAA regulations, we will ask permission from you to photograph your child and would like you to check beside each item that you consent to use your child's photo for:

Recording progress in the child's chart: ☐ Yes ☐ No _____ _____ Parent/Guardian Initials

For use in a professional presentation: ☐ Yes ☐ No _____ _____ Parent/Guardian Initials

For use in a professional publication: ☐ Yes ☐ No _____ _____ Parent/Guardian Initials

PARENT RESPONSIBILITIES
We agree to be financially responsible for all charges incurred at this office. We will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, ***a 15% interest charge will be added to the balance due.*** We are liable for any cost incurred by the office in collection efforts.

CANCELLATION POLICY
If you are unable to make your appointment, please provide at least 24-hour notice of cancellation. ***A cancellation fee of $50 will apply for appointments cancelled with less than 24-hour notice.***

_____

Signature Date

Our office requires a credit card to be kept on file for any charges incurred.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
This document is to be signed by persons legally responsible for the patient's medical decisions relative to the treatment situation.

We, _____, hereby acknowledge that we have been provided with a copy of the Notice of Privacy Practices that describes how medical information about our child/guardian may be used and disclosed, and how we can access that information. We understand that if we have questions or complaints, I may contact: **Faraneh Carnegie-Hargreaves, DC, Karen Peck CTRS, CST, QST**; or **Sharon A. Vallone, DC, FICCP at 860.432.9923.**

We also understand that we are entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

_____

Parent/Guardian 1 Signature Date

_____

Parent/Guardian 2 Signature Date

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.
I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:
[ ] Patient declined to sign this written acknowledgement.
[ ] Other (specify):_____

_____

Name and title of employee Date