|  |  |
| --- | --- |
| **A screenshot of a cell phone  Description automatically generatedWellSpring:****Integrative Health Care**~Intelligent Health Care~ | 3221 S. Cherokee Ln Ste 1830  770.376.0632 tel.Woodstock, GA 30188  Secure fax: 770.783.6338 |

**DEMOGRAPHIC INFORMATION**

Name Today’s Date

Address Parent Name(s)

City, State, Zip Parent Occupations(s)

Phone (home)

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age Parent Employer(s)

Gender: □ F □ M Height: \_\_\_\_ ft \_\_\_\_ in Weight:

Medical Doctor Parent Email

Date of last check-up Parent Work Phone

School currently attending Parent Cell Phone

Travel time to this office Referred to our office by

Name/Age of Sibling(s)

Other Household Members (include extended family, non-family and pets)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person responsible for payment of professional services

Practitioners at the Lydian Center you have previously seen:

**CURRENT HEALTH REPORT**

What are the primary health or developmental concerns with this young person?

1.

2.

3.

**BIRTH HISTORY**

Was your child adopted? \_\_\_\_\_\_ If so, at what age? \_\_\_\_\_\_

Term: Full / Premature / Late \_\_\_\_ C-Section? \_\_\_\_\_\_ Did mother go into labor? \_\_\_\_\_\_ Length of Labor

Weight at Birth \_\_\_\_\_\_\_\_ Birth/fetal pregnancy complications

Feeding: □ Breast fed How long? \_\_\_\_\_\_ □ Formula □ Milk/Soy Solid foods at age

Sleep pattern during first year

Does s/he sleep well now?

As a baby did s/he experience:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Allergies | □ Colic | □ Fever | □ Rashes |
| □ Birth Injury | □ Diarrhea | □ Jaundice | □ Seizures |
| □ Birth Defects |  |  |  |

**DEVELOPMENTAL HISTORY**

**Physical Development**

Age began: Rolling over \_\_\_\_\_\_\_\_\_\_\_\_ Sitting \_\_\_\_\_\_\_\_\_\_\_\_ Crawling \_\_\_\_\_\_\_\_\_\_\_\_ Walking

Any difficulties with:

|  |  |  |
| --- | --- | --- |
| □ Crawling | □ Somersaults | □ Throwing/Catching a Ball |
| □ Walking | □ Climbing | □ Activities on the Playground |
| □ Running | □ Riding a Bike | □ Gross Motor Activities |
| □ Hopping | □ Swimming | □ Fine Motor Activities |

□ Skipping □ Organizing/Remembering Sequential Activities or Thoughts

If any difficulties, please explain:

**School History, Language and Social Development**

Current Grade Level \_\_\_\_\_\_\_\_ Current Grade Level for Reading \_\_\_\_\_\_\_\_ Current Grade Level for Writing

Areas of Academic Ease

Areas of Academic Difficulty

Favorite Subjects

Unusual skills or interests:

Desire, ease and ability to communicate with:

Parents Peers Adults

Siblings Older Children Strangers

Describe his/her relationships with siblings:

Is s/he a Leader? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Follower? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Socially flexible?

Does s/he have many friends? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A few close friends?

How easily does s/he listen and cooperate with others? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Follow Instructions?

Emotional traumas:

Extended family (or committed adult family friends) with whom this young person has regular contact:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notable developmental histories of biological siblings:

**Sensory Integration Issues**

Sensitivity to: □ Light □ Sound □ Smells □ Tactile Stimulation □ Picky Eater (texture/taste)

**DIET AND LIFESTYLE**

Please describe his/her typical daily diet:

Breakfast

Lunch

Dinner

Snacks

Sweets

Food cravings:

Any known food, environmental or medication allergies/intolerances? Please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does s/he routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what?

Artificial colors/sweeteners? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has s/he ever tried a gluten free/dairy free diet?

How many hours per day does s/he spend:

|  |  |
| --- | --- |
| \_\_\_\_ hours playing outdoors (weather permitting) | \_\_\_\_ hours of unstructured time in imaginary play |
| \_\_\_\_ hours of computer time | \_\_\_\_ hours of unstructured time with friends |
| \_\_\_\_ hours watching TV/video |  |

Favorite activities

**MEDICAL HISTORY**

**Injuries**

Head injuries

Other major falls or injuries

Other traumatic events

Surgeries/Hospitalizations

**Illnesses**

Has s/he had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Bronchitis | □ Tonsillitis | □ Measles | □ Colic |
| □ Croup |  number of times \_\_\_ | □ Mumps | □ Persistent Diaper Rashes |
| □ Frequent Colds | □ Ear Infections | □ Rubella | □ Bedwetting |
| □ Pneumonia |  number of times \_\_\_ | □ Antibiotic Prescriptions |  |
| □ Chicken Pox | □ Scarlet Fever |  approximate number in lifetime \_\_\_\_ |

**Immunizations**

Has s/he had standard childhood vaccinations? □ yes □ no Any adverse reactions? Please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When his/her condition first appeared, about how long was it after their most recent vaccination, and which vaccination was that? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**

Please write either C, O or P for each: **C** = Constantly in the present **O**  = Occasionally in the present **P**  = In the past

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_ acne | \_\_\_\_\_ bloody urine | \_\_\_\_\_ flat feet |
| \_\_\_\_\_ excema | \_\_\_\_\_ hearing loss | \_\_\_\_\_ joint pains |
| \_\_\_\_\_ hives | \_\_\_\_\_ heart murmur | \_\_\_\_\_ nervousness |
| \_\_\_\_\_ asthma | \_\_\_\_\_ anemia | \_\_\_\_\_ dizzy spells |
| \_\_\_\_\_ high fevers | \_\_\_\_\_ stomach aches | \_\_\_\_\_ body/breath odor |
| \_\_\_\_\_ chronic rash | \_\_\_\_\_ constipation | \_\_\_\_\_ motion/car sick |
| \_\_\_\_\_ canker sores  | \_\_\_\_\_ diarrhea | \_\_\_\_\_ nightmares |
| \_\_\_\_\_ sore throat | \_\_\_\_\_ gas  | \_\_\_\_\_ unusual fears |
| \_\_\_\_\_ wheezing | \_\_\_\_\_ no appetite | \_\_\_\_\_ night sweats |
| \_\_\_\_\_ bleeding gums | \_\_\_\_\_ insatiable hunger | \_\_\_\_\_ cries easily |
| \_\_\_\_\_ nose bleeds | \_\_\_\_\_ jaundice | \_\_\_\_\_ inconsolable crying |
| \_\_\_\_\_ burning urination | \_\_\_\_\_ bruises easily | \_\_\_\_\_ excessive fatigue |
| \_\_\_\_\_ frequent urination |  |  |

Any other condition not previously mentioned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any current medications (prescription and non-prescription):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMAGING AND SPECIAL STUDIES**

 When Where Results

Hearing Test \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Vision Test \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Speech/Language \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Behavioral Assessment \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

X-ray \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Has any immediate family member had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Allergies | □ Birth Defects | □ Diabetes | □ Hypertension |
| □ Arthritis | □ Cancer | □ Heart Disease | □ Mental Illness |

Health of biological siblings

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous pregnancies by birth mother, miscarriages or complications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s health during pregnancy:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Alcohol consumption | □ Drug use | □ Nausea | □ Tobacco use |
| □ Bleeding | □ Illness | □ Thyroid problems | □ Diabetes |
| □ Physical/emotional trauma | Mother’s age at child’s birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Your completion of this Intake Form will help us determine whether our services might help your child. Upon our review of this Form, we will contact you to set up an initial appointment as a new patient, or, if we believe that the Practice’s services may not meet your child’s needs, we may offer to discuss possible alternative practitioners at the center. In both cases, we will maintain the information you have provided in this Intake Form in a confidential manner in accordance with our privacy practices, regardless of whether your child becomes a patient of the Practice.

Please note that each practitioner practicing at the center owns and operates his/her own clinical practice and is not affiliated with WellSpring:IHC. While we may work closely with the practitioner(s) we discuss with you, we are not liable for any care or treatment provided by him/her. In addition, we would like to remind you that you have the right to seek treatment and care for your child from any practitioner at any facility you choose.

**Because some of our patients have allergies, we ask you not to wear scented products (e.g., perfumes, hair products, aftershaves, clothing dried with Bounce® dryer sheets) to this office. Please check here to acknowledge this request: □**