Midwest
Women's & Children's
Specialty Group
an affiliate of MEDNAX

10550 Quivira Road, Suite #520
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We are pleased and honored that you have chosen Midwest Women's and Children's Specialty Group for your child's care.

In an effort to provide you the best and most efficient service, we need your cooperation in providing us with all of the information you may have that will help in the management of your child. **We ask that all records and completed paperwork be sent to our office within seven days of the referral.**

Please review and answer the questions below.

1. Has your child been evaluated by Early Intervention Program (Infant & Toddlers or MO First Steps?
   Yes____ No____
2. Has your child seen a speech therapist, occupational therapist, or physical therapist or audiologist?
   Yes____ No____
3. Has your child seen a psychologist, developmental specialist, neurologist, or psychiatrist?
   Yes____ No____
4. Has your child been evaluated by your school district and has an IEP?
   Yes____ No___
5. Do you have any information not listed above that is related to your child's condition?

To complete your registration you must return to our office:

- This cover letter (showing your answers to the five questions above)
- New Patient Intake Form (9 pages)
- Records pertaining to any question above marked "Yes"

Once all the necessary documents are received, we will schedule your child for an appointment. Please be aware initial visits may take 90-120 minute. We encourage you to bring your child alone, or bring another responsible adult if younger siblings will accompany you during your first visit.

Please note: An appointment will NOT be scheduled until all necessary documents are in our office. This is necessary to provide the best care assessment for you and your child.

We look forward to providing your child the best care!

Thank you,

Developmental Team

913-310-0482

NEW PATIENT INTAKE FORM

Please complete the following. If you need additional space, you may write on the back of the form or attach a separate sheet of paper.

Today's date: ______________________ Date of Appointment ______________________

Child’s Name: ____
First Middle Last

Child’s Nickname: ____

Birthdate: ______________________ Age: ______________________

Address: ____
Number and Street City, State, Zip

Telephone Number: ____

Person completing form: ____

Relationship to Child: ____

Child's Primary Care Physician: ____

Physician's Phone Number: ____

Your Insurance Provider: ____

Referred to Clinic by: ____

Reason for Referral, Primary Concerns:

1. ____
2. ____
3. ____
4. ____

Mother	Father
Name: ______________________	Name: ______________________
Address: ______________________ (if different than child)	Address: ______________________ (if different than child)
______________________	______________________
Tel: H__________ W __________	Tel: H__________ W __________
Email: ______________________	Email: ______________________
Age: ________ Education: ________ (highest grade)	Age: ________ Education: ________ (highest grade)
Occupation: ______________________	Occupation: ______________________
Employer: ______________________	Employer: ______________________
Marital Status:	Marital Status:
Single Married Divorced Remarried	Single Married Divorced Remarried

Relationship of caretaker to child:

Father:	Biological	Adoptive	Foster	Step
Mother:	Biological	Adoptive	Foster	Step

List additional caretakers, relationship, address, and phone number(s):

____

____

____

____

If child is adopted, at what age did this occur? ______________________

Brothers and /or Sisters:

	Name	Age	Sex	Where living?	Problems
1.					
2.					
3.					
4.					

Other persons now living in the home:

	Name	Age	Sex	Relationship to Child
1.				
2.				
3.				
4.				

PRENATAL HISTORY:

List all of mother's pregnancies - include miscarriages and this child:

	Year	Sex	Length of Pregnancy	Birth Weight	Vaginal/ C-Section	Complications
1.						
2.						
3.						
4.						
5.						
6.						

Prenatal History, cont.:

Check the following which occurred during this pregnancy:

____ High Blood Pressure
____ Flu
____ High Fever
____ Hospitalization

_____ Vaginal Bleeding
_____ Accidents/Falls
_____ Infections
_____ Amniocentesis

Check substances used during this pregnancy:

____ Antibiotics
____ Prenatal Vitamins
____ Cold Preparation
____ Seizure Medication
____ Thyroid Medication
____ Tobacco

_____ Marijuana
_____ Alcohol
_____ Amphetamines
_____ Cocaine/Crack
_____ PCP
Other ____

BIRTH HISTORY:

Due Date: ____________________ Actual Date of Delivery: _______________________________

.Labor: Induced _________ Spontaneous ________ General anesthesia used: ___________________

Type of Delivery: Vaginal _______ C-Section _______ Forceps used __________________

Apgar score: 1 min. _____ 5 min. _____ Birth Weight __________ Length _____________

Newborn Problems:

Anemia
Infection
Needed Oxygen

Jaundice
Required Phototheraphy
Other: ____

Breast or Bottle Fed: ____

Length of Hospital Stay: ____

DEVELOPMENT:

Age of Child:

_______ Sat without support
_______ Crawled
_______ Walked
_______ Spoke single words

_______ Undressed self
_______ Dressed self
_______ Pedaled tricycle
_______ Tied shoelaces

Development, cont.:

_______ Fed self with spoon   _______ rode bicycle
_______ Spoke sentences

Was this a "cuddly" baby?	Yes _______	No _______
Was this an "active" baby?	Yes _______	No _______
Was this a "colic" baby?	Yes _______	No _______

TOILETING:

How old was child when you started toilet training? ____

Age at which bowel training achieved? ____

Does your child wet or soil during the day ___________________ or night ____________________________ ?

MEDICAL IDSTORY:

Has your child had any of the following?.

_____ Chronic ear infections	_____ Hearing problems	_____ Broken bones
_____ Eye problems	_____ Sinus infections	_____ Tic Disorder
_____ Head injuries	_____ Seizures/convulsions	_____ Prolonged or high fever
_____ Meningitis	_____ Asthma	_____ Sutures

Any severe illness or medical problems? ____

Operations/Hospitalizations? ____

Allergies: ____

Fever: ______ How high: _______ Time of Day: _______ Seizures Associated with it: _____________

Current Medications: ____

Immunizations: ____

Immunizations (Are they current?): _______Passed? _______

Immunizations (Unusual reactions): ____

Has your child had an eye exam? ________ When? ________________________ Passed: __________________

Medical History, cont.

Has your child had a hearing exam? ______ When? _____________________ Passed: __________________

Does your child complain of:

Headaches, frequency and time of day: ____

Stomachaches, frequency: ____

_____ Weakness

_____ Pain somewhere

_____ Chronic constipation

_____ Chronic diarrhea

Is your child _____ or left _____ handed?

SLEEPING HABITS:

Age at which child began sleeping through the night? _______________________________________

Current bedtime: _____________ With whom does he/she sleep? _____________________________

Does child get up during night? Yes _____ No ______ Why? __________________________________

Has your child had nightmares or night terrors ? _________Sleepwalks? __________________________

Any changes in sleep habits in the past 6 months? ____

EATING HABITS:

Child's appetite: Eats constantly _____ Average _____ Picky eater _____

Significant weight loss _____or gain ______Why? ____

Does your child have food allergies? _____ What foods: ____________________________________

Problems around meal time: ____

Favorite foods: ____

BEHAVIOR: (Check the items which apply to your child.)

_____ Inattentive, day dreams
_____ Impulsive, can't wait turn
_____ Noncompliant with rules
_____ Bothers other children
_____ Doesn't finish work
_____ Destructive Behavior
_____ Uncooperative with teacher
_____ Does dangerous things
_____ Inconsiderate of others
_____ Aggressive
_____ Tells lies
_____ Hyperactive
_____ Resists change
_____ Temper Tantrums
_____ Clumsy
_____ Poor self esteem
_____ Trouble making friends
_____ Fails to take responsibility
_____ Gets into fights
_____ Steals
_____ Moody
_____ Unusual fears
_____ Accident Prone
_____ Poor Memory

DISCIPLINE:

_____ Spanking _____ Time Out _____ Send to Room _____ Withhold privileges _____ Reasoning

Other: ____

What method is most effective? ____

Who is best at disciplining child? ____

Do both parents agree on discipline? Yes _____ No ______ Explain _____________________________

PLAY:

Who are child's best friends? ____

Is your child the best friend of someone? ____

Favorite activities: ____

JOBS:

What are your child's responsibilities at home? ____

Does your child have responsibilities away from home? ___________________________________

Does your child comply and do his responsibilities? ______________________________________

SCHOOL HISTORY:

Grade ____________ Name of School ____________________________________ Telephone ______________

School District ____ Teacher ___________________________

Special Classes ____

Repeated a grade? _________ Which grade(s)? ____

Has your child been tested by the school team? __________ When? _____________________________________

Child's Behavior

Preschool	_____ Good	_____ Average	_____ Poor
Kindergarten	_____ Good	_____ Average	_____ Poor
Grades 1-3	_____ Good	_____ Average	_____ Poor
Current Grade	_____ Good	_____ Average	_____ Poor

Child's favorite subjects: ____

What does child do well? ____

What does child do poorly? ____

FAMILY MEDICAL HISTORY:

Has anyone-in the immediate or extended family had any of the following? (Include grandparents, cousins, uncles, aunts.)

Endocrine Disorders (e.g.: Thyroid, Diabetes,_etc.) ____

Neurological Disease, who? ____

Seizure Disorder, who? ____

Psychosis (e.g. Schizophrenia) ____

Mental Illness, who? ____

Behavior Problems, who? ____

Family Medical History, cont:

Alcoholism, who? ____

Learning Problems, who? ____

Hyperactivity, who? ____

Hearing Problems, who? ____

Tic Disorder, who? ____

Do any other physical diseases run in the family? ____
(describe)

____

____

FAMILY:

Have there been any significant changes in your child's life in the past year?

_____ Death of a Relative
_____ Death of a Pet
_____ Move
_____ Best friend moving
_____ Problems with friends
_____ Divorce or Separation
_____ New Child in Family
_____ New School

_____ Other ____