PHYSICIANS' CLINIC
of Iowa, P.C.

NEW MINOR PATIENT INTAKE FORM

Child's First Name ______________________________ Middle Initial_____ Child's Last Name ____

Child's Address: ____

Child's Age: _____ Child's Date of Birth: ____________________ Gender: ☐ Male ☐ Female Current School: __________________________________

Grade: ________ Teacher Name in School: ____

Form Being Completed By: ____ Primary Phone: ________________________ Today's Date: ____________

Parent Information

Parent 1 Name: ____ Age: ______ Primary Phone: ____________________________________

Address (if different from child's):____

Relationship to Child: ☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Foster Parent ☐ Court Appointed Legal Guardian

Education (last grade finished): ________ Occupation: ____

Parent 2 Name: ____ Age: ______ Primary Phone: ____________________________________

Address (if different from child's):____

Relationship to Child: ☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Foster Parent ☐ Court Appointed Legal Guardian

Education (last grade finished): ________ Occupation: ____

Parent/Legal Guardian must be present for the scheduled appointment.

If you are not the parent, court documentation regarding guardianship will be required prior to scheduling an evaluation. Please send a copy of your court documentation with questionnaire.

Family Information

Marital Status of Child's Parents: ☐ Married (how long? ______) ☐ Separated (how long? _______) ☐ Divorced (how long? _______) ☐ Never Married

☐ Father Re-married (how long? ______) ☐ Mother Re-married (how long? _______) ☐ Both Parents Deceased (how long? _______)

☐ One Parent Deceased (how long? _______) ☐ Other

If divorced, name of custodial parents: ____

Does child have visitation with non-custodial parents ☐ Yes ☐ No If yes, how often: ______________

Name and address of non-custodial parent: ____

May we request his/her participation in the child's evaluation at this clinic? ☐ Yes ☐ No

Caregiver Information

Please list any other children by name and note if they have health, learning or behavior issues:

First and Last Name	Age	Relationship to You	With Whom Are They Living?	Problem (If Any)

Please list any other people living in the home (for example, grandparent, uncle, fiancee)

First and Last Name	Age	Relationship to You	Male or Female

Please continue to the back side ⟶

Please check your concerns:

- ☐ Self help/independent skills
- ☐ Speech/language
- ☐ Ability to relate to peers/adults
- ☐ Does not follow rules
- ☐ Non-compliance
- ☐ Aggression/fighting
- ☐ Rigid/can't adapt to change in schedule
- ☐ Repetitive behaviors (hand flapping, rocking)
- ☐ Learning (math, reading, writing)
- ☐ Disorganization
- ☐ Work completion
- ☐ Attendance at school
- ☐ Anxious/worried
- ☐ Depressed/sad
- ☐ Substance abuse
- ☐ Self harm
- ☐ Sleep problems
- ☐ Eating problems
- ☐ Sensory (over or under sensitive)
- ☐ Getting along with siblings
- ☐ Sexual Activity

Other: ___________________________________

Please explain items checked: _______________
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Describe behavior at home: ____
____

Describe behavior at school: ____
____

Describe behavior problems in the community: ____
____

What has been done to attempt to solve these issues: ____
____

What type of help would you like us to give you and your child? ____
____

Child's Medical Conditions:

- ☐ Surgery: ______________________ Date: __________
- ☐ Serious Illness: ________________ Date: __________
- ☐ Accident:_____________________ Date: __________
- ☐ Head Injury Date: __________
  Number_____ Type ________________
- ☐ Chronic Ear Infections
- ☐ Hearing Difficulty
- ☐ Abuse
  When? ___________
  By Whom? ________
  Reported? ________
  Outcome? ________
- ☐ Abnormal Eating Behavior
- ☐ Kidney Infection
- ☐ Eye/Vision Problems
- ☐ Allergies: ____Food ____Medicines

Please explain items checked: _______________
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Prenatal Information

- ☐ Nausea and vomiting
- ☐ Infectious disease
- ☐ German measles
- ☐ Urine abnormality
- ☐ Gestational diabetes
- ☐ Anemia
- ☐ High blood pressure/pre-eclampsia/toxemia
- ☐ Swelling or edema
- ☐ Prescription medication use, please list
  ____
  ____
  ____
- ☐ Alcohol or drug use
- ☐ Cigarette use
- ☐ Previous miscarriages
- ☐ Previous still birth

Birth Conditions

Birth Weight: _____

- ☐ Premature
  _____ Gestation age in weeks
- ☐ Long labor
- ☐ Baby had trouble breathing
- ☐ Convulsions
- ☐ "Blue baby"
- ☐ Jaundice
- ☐ Needed incubator
- ☐ Swallowing difficulty
- ☐ Home delivery
- ☐ Other ________________________________

Please explain items checked: _______________
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Developmental Milestones - at what age did your child do the following?

Roll over _____ Months
Speak first word _____ Months
First tooth _____ Months
Dress him/herself_____ Months
Potty trained, day _____ Months
Potty trained, night _____ Months
Speak 2 to 3 word sentences _____ Months
Sit without help _____ Months
Ride a trike _____ Months

Please explain: __________________________
____
____
____
____
____

Patient Signature: ____ Date: ___________________________________

This form is destroyed after the information is entered and verified in the patient's electronic health record.

Please record the names and contact information of the people who have worked with your child and your family.
All providers should fax records to 877-781-3981.

	Name	Address	Email	Phone
Primary Care Physician				
Name of DHS worker (if applicable)				
Name of Juvenile Court Officer (if applicable)				
Name of Guardian Ad-Litem (if applicable)				
Name of other Agency (if applicable)				
Therapist, Counselor or Physician (if applicable)				
Any other persons/agencies that may provide valuable information concerning the child				