NewYork-Presbyterian
Phyllis and David Komansky
Center for Children's Health

Weill Cornell Medicine

Appointment Location: 505 East 70th Street 3rd Floor – Pediatric Subspecialty Clinic

Intake History Questionnaire

Child's name:_____

Child's date of birth:_____

Parents' names: _____

Who referred you for this evaluation? _____

Please answer all the following questions, which will help us plan for your child's evaluation

What concerns do you have about your child's development and/or behavior;

_____

_____

_____

What information would you like to gain from this evaluation?

_____

_____

MEDICAL HISTORY

Child's weight at birth? _____ lbs _____ oz

Was your child born full term? Yes No

If not, at what week of gestation? _____ weeks, or

What type of delivery?

_____ Vaginal delivery (_____ normal/spontaneous _____ Pitocin induced)
_____ Cesarean section – if so, was this due to:
_____ repeat
_____ fetal distress

How old was the mother at the time of delivery? _____ Years

What number pregnancy was this (e.g. 1st, 2nd, etc.)?_____

If any prior pregnancies, how many resulted in a delivery?_____

Hospital where child was born? _____

Was your child adopted? Yes No

If yes, where was your child born?_____

How old was your child when he/she was placed in your care? _____

Was your child conceived through in vitro fertilization? Yes No

Did the mother receive fertility therapy? Yes No

Was your child a singleton or a multiple birth? Singleton Multiple

If a multiple birth, how many children were delivered? _____

What were their birth weights? _____

Were there any maternal medical problems during the pregnancy? Yes No

If yes, what was/were the problem(s)?

_____ Bleeding _____ Diabetes _____ Infection _____ Hypertension

Were any medications taken during the pregnancy? Yes No

If yes, please list medication(s) and reasons taken?_____

_____

Did you have a fetal sonogram? Yes No

Result(s) of sonogram(s)? _____ Normal _____ Abnormal

If abnormal, please explain:_____

_____

Was the infant's stay in the nursery:
_____ Uneventful _____ Complicated

If complicated, please describe:_____

_____

Did the infant leave the hospital with mother after usual post-partum stay? Yes No

Current and Past Medications and Supplements

Medication/ Supplement	Dose	Reason for Taking	Start Date/ End Date

Does you child have known allergies to food or medications? Yes No
If yes, please list:_____

Are your child's immunizations up to date? Yes No

Pediatric care is provided by: (If you wish a copy of the report from this evaluation go to your Pediatrician please include the Doctor's full mailing address)

Doctors Name:_____

Address:_____

Has your child had or been diagnosed with any of the following conditions:

Abnormal Hearing Test	Yes	No
Ear infections	Yes	No
ADHD	Yes	No
Anemia	Yes	No
Anxiety	Yes	No
Asthma	Yes	No
Atopic Dermatitis	Yes	No
Atrial Septal Defect	Yes	No
Autism Spectrum Disorder	Yes	No
Cardiac Arrhythmia	Yes	No
Cerebral Palsy	Yes	No
Chronic Lung Disease	Yes	No
Depression	Yes	No
Developmental Delay	Yes	No
Feeding Difficulties	Yes	No
Genetic Disorder	Yes	No
GERD (Gastric reflux)	Yes	No
GI Problem	Yes	No
Hearing Loss	Yes	No
Heart murmur	Yes	No
Intraventricular Hemorrhage	Yes	No
Jaundice (Neonatal)	Yes	No
Meningitis	Yes	No
Motor Skills Delay	Yes	No
Otitis Media	Yes	No
Patent Ductus Arteriosus	Yes	No
Pervasive Developmental Disorder	Yes	No
Prematurity	Yes	No
Scoliosis	Yes	No
Seizure Disorder	Yes	No
Speech Delay	Yes	No
Urinary Tract Disorder	Yes	No
Ventricular Septal Defect	Yes	No
Visual Impairment	Yes	No

If yes, please explain:

Other

Has your child had any of the following surgical procedures?

Adenoidectomy	Yes	No
Tonsillectomy	Yes	No
Tympanostomy Tube Placement	Yes	No
Strabismus Surgery	Yes	No
Sinus Surgery	Yes	No
Hernia Repair	Yes	No
Hypospadias Repair	Yes	No
Gastrostomy Tube	Yes	No
Nissen Fundoplication	Yes	No
Tendon Release	Yes	No
Tracheostomy	Yes	No
Ventriculoperitoneal Shunt	Yes	No

If yes, please explain:
_____
_____
_____

Other history: _____

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DEVELOPMENTAL HISTORY

Please list the ages at which your child:

Rolled over _____ Sat up _____

Stood up _____ Walked alone_____

Babbled _____ Said mama/dada _____

Single words _____ 2 - word phrases _____

Toilet trained: During the day_____ At night:_____

Other:_____

School History/Type of Classroom:

Toddler groups/classes_____

Nursery School_____

Pre K_____

Kindergarten_____

Grade1_____Grade2_____

Grade 3_____ Grade 4_____

Grade 5_____ Grade 6_____

Grade 7_____ Grade 8_____

Other _____

Number of: Students _____ Teachers _____ and Aides _____

Has your child ever had any of the following evaluations?

	Evaluator	Date	General Findings

Audiology/Hearing test:_____

Vision:_____

Physical Therapy:_____

Speech & Language:_____

Psychology:_____

Neurology:_____

Occupational Therapy:_____

Other:_____

_____

Has your child received any therapies?

	Frequency	Start Date	End Date

Physical Therapy:_____

Speech & Language Therapy:_____

Occupational Therapy:_____

SEIT Services :_____

ABA Therapy :_____

Other:_____

Sleep & Feeding:

Child usually goes to sleep at _____ PM Child wakes up at _____AM

Child does / does not sleep through the night?

Is there any snoring, difficulty breathing during sleep, nightmares?_____

Does the child sleep in a crib or bed?_____

Does he/she share a room?_____

Does you child still nap/ how often?_____

Please describe your child's diet:_____

_____

Is your child on a special diet?_____

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FAMILY COMPOSITION

Mother/Father name_____ Age____ Education level _____ Occupation _____
(please circle one)

Mother/Father name_____ Age____ Education level _____ Occupation _____
(please circle one)

Please list the child's siblings:

* Name_____ _____age male / female

* Name_____ _____age male / female

* Name_____ _____age male / female

Does anyone else live in the family home _____

Does your child have a regular caretaker other than parents?_____

Languages spoken in the home_____

Is there any biological family history of the following conditions:

Allergies	Yes	No
Anxiety Disorder	Yes	No
Asthma	Yes	No
Attention deficit disorder	Yes	No
Autism Spectrum	Yes	No
Bipolar Disorder	Yes	No
Depression	Yes	No
Developmental Disability	Yes	No
Genetic Disorder	Yes	No
Heart Disease	Yes	No
Hypertension	Yes	No
Intellectual Disability	Yes	No
Learning Disability	Yes	No
Schizophrenia	Yes	No

If yes, please explain:

_____

_____

If your child is **under 5 years** of age please complete the following:

My child feeds him/herself with fingers	Yes	No	Sometimes
My child feeds him/herself with utensils	Yes	No	Sometimes
My child can drink from an open cup	Yes	No	Sometimes
My child can wash his/her hands and face	Yes	No	Sometimes
My child can brush his/her teeth	Yes	No	Sometimes
My child can undress him/herself	Yes	No	Sometimes
My child can dress him/herself	Yes	No	Sometimes
My child performs simple household chores	Yes	No	Sometimes
My child plays appropriately with toys	Yes	No	Sometimes
My child can play independently	Yes	No	Sometimes
My child shares his/her toys well	Yes	No	Sometimes
My child enjoys playing with other children	Yes	No	Sometimes
My child asks for friends by name	Yes	No	Sometimes
My child can play a turn taking game	Yes	No	Sometimes
My child enjoys playing dress up	Yes	No	Sometimes
My child comes to greet me when I come home	Yes	No	Sometimes
My child shows separation anxiety when I leave	Yes	No	Sometimes
My child spontaneously expresses affection	Yes	No	Sometimes
My child comforts other children in distress	Yes	No	Sometimes
My child shows pride in his/her accomplishments	Yes	No	Sometimes
My child brings me toys and books to share	Yes	No	Sometimes
My child will ask for help if needed	Yes	No	Sometimes
My child will say please and thank you	Yes	No	Sometimes
My child follows directions	Yes	No	Sometimes
My child responds when I call his name	Yes	No	Sometimes
My child uses gestures to communicate	Yes	No	Sometimes
My child uses words to communicate	Yes	No	Sometimes
My child uses sentences to communicate	Yes	No	Sometimes
My child asks questions	Yes	No	Sometimes
My child uses the following # of words	< 5, 5 to 20 , 20 to 50 , More than I can count		
My child walks well	Yes	No	Sometimes
My child can walk up and down stairs	Yes	No	Sometimes
My child runs well	Yes	No	Sometimes
My child will play ball games	Yes	No	Sometimes
My child participates in team games	Yes	No	Sometimes
My child can scribble	Yes	No	Sometimes
My child can draw a recognizable figure	Yes	No	Sometimes
My child can write his/her name	Yes	No	Sometimes

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Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

- ☐ Albanian
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Cantonese (Chinese)
- ☐ Creole
- ☐ Croatian
- ☐ ECH
- ☐ Danish
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Latin
- ☐ Malay
- ☐ Mandarin (Chinese)
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russia
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Yugoslavian
- ☐ Other
- ☐ Declined
- ☐ Unknown

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino or Spanish Origin
- ☐ Not Hispanic or Latino or Spanish Origin
- ☐ Declined

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Pharmacy Intake Form

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New ☐ Update

Date:

Patient Name:

NYH #:

PRIMARY
Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)
Pharmacy Name:

Address:

Phone Number:

Fax Number:

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Weill Cornell Medical College (WMCC)
Privacy Office Forms

Authorization To Disclose Health Information Via E-Mail

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ ST: ____ Zip: _____ Phone: _____

This authorization covers protected health information (PHI) disclosed by Weill Cornell Medical College (WCMC) personnel to a patient or a patient's representative through e-mail communication. It expires when the need to communicate via e-mail is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

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To be completed by patient or patient's representative:

My signature at the bottom of this form is authorization for WCMC to disclose the health information of the above-named patient via e-mail. It also confirms my understanding that:

- Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Re-disclosure may no longer be protected by law.
- I should not use e-mail for any urgent or time-sensitive medical questions or issues
- Once transmitted, I am responsible for safeguarding the information I receive
- I have the right to revoke this authorization at any time before information is disclosed by submitting to the Privacy Office a WCMC Revocation of Release of Medical Information Form # PO012B. A revocation will not apply to information that has already been released as a result of this authorization
- To initiate e-mail communication, I will send an e-mail from my e-mail address, containing my request for information, to the WCMC party at the e-mail address below
- I am responsible for notifying the WCMC party listed below if my e-mail address changes and completing another authorization in order to communicate using a different address
- If I am communicating via e-mail about someone else, I attest that I am responsible for that person's care or payment and will indicate my relationship to the patient below
- WCMC will not condition treatment or payment upon receipt of an authorization

The e-mail address I wish to use is: _____

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient

****

To be completed by WCMC:

Name of WCMC party (please print): _____Child Development_____

WCMC e-mail: ___pedschilddevelopment@med.cornell.edu, ckm2003@med.cornell.edu, kmt2003@med.cornell.edu__

WCMC, please indicate date completed: _____, retain a copy of this request in the patient's file, and provide a copy of the original to the requestor