OUTPATIENT SPECIALTY CLINIC
STRAMSKI CHILDREN'S DEVELOPMENTAL CENTER
2651 Elm Ave #205 Long Beach CA 90806 Phone 562-728-5034 Fax 562-490-9413

Pre-Admission Form

(Please fill out all sections completely and accurately) Intaker's Initials:___________
Today's Date:________________ Appointment Date:______________Time: ________am/pm
Referred to MD:______________ Referring MD: ________________________ Telephone: ________

Patient Information
Patient's Last Name: _____________________________ First Name:____________________ MI:________
DOB: ____________ Sex: M / F Alias:____________________
Address: _________________________________Apt #: ______ City: ___________________ Zip: ________
Home Telephone #: _______________________ May we leave a message on this number? Y N
SSN: _______-_____-__________ Language: ___________ Race: ___________Religion: _______________
Primary Caretaker: _______________________ Relationship to Patient: _____________________
Cell #: ____________________________ May we leave a message on this number? Y N
Email: ____________________________ May we contact you on this address? Y N
Secondary Caretaker: _____________________ Relationship to Patient: _____________________
Cell #: ____________________________ May we leave a message on this number? Y N
Email: ____________________________ May we contact you on this address? Y N

In case of an emergency *(Someone other than parents)*
Emergency Contact Name: ______________________________ Day Telephone: (____)______-__________
Relationship to Patient: ____________________ Home Telephone: (____)_____-__________

Responsible Party (Guarantor) *(Is Caretaker 1 or Caretaker 2 the Guarantor? If so indicate "same as above")*
Last Name: _____________________________________ First Name: ______________________
Address *(if different from above)*: ____ Zip:______________
Home Telephone #: ______________________________ Work Telephone #: ____________________
Cell Telephone #: _______________________________DOB: _____________
Sex: M / F SSN: _______-____-___
Employed by: ____
Employer's Address: ____

Primary Insurance Information *(send copy of insurance card)*
Insurance Type: ☐HMO ☐MCAL ☐MCAL HMO ☐CCS ☐PPO ☐EPO ☐POS ☐Other________
Insurance Name: __________________________ IPA/Medical Group: ___________________
Telephone: ___________________ Fax: ____________________
Claims Mailing Address: ____ City: _____________
Subscriber: _______________________________ SSN: ______-______-_________Group #:___________
Eligibility Date: ___________________________ Deductible/Share of Cost/Co-pay: $_______
Primary Care Provider: ___________________________ Address: ____________________________
City: _______________________ State: _______ Zip:________ Telephone: (_____)_____-____
Fax #: (_____)_____-__________ Authorization #: _______________________ Expiration: ______________
Authorization Form Attached: Yes / No Parent to Bring Authorization Yes / No

MemorialCare
Miller Children's & Women's Hospital Long Beach

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NEW PATIENT INTAKE FORM (6-21 y/o)

Complete **BEFORE** your child's appointment. This helps for a more focused visit to address your concerns. Also, if your child has had any evaluations from school or other centers, please bring so that Doctor or Nurse Practitioner can review.

PATIENT INFORMATION

Child's Name: ______________________ Birth Date: ______________________

Gender: ______________________ Age: ______________________

ALL Parents or Legal Guardians:

Name: ______________________ Relationship to patient: ______________________

Best Contact #: ______________________

Name: ______________________ Relationship to patient: ______________________

Best Contact #: ______________________

Name: ______________________ Relationship to patient: ______________________

Best Contact #: ______________________

Name: ______________________ Relationship to patient: ____________

Best Contact #: ______________________

PURPOSE OF CONSULTATION

Why are you seeking help for your child? List main concerns:

____

____

What would you like our center to do for your child, or family?

____

____

What attempts have you made already to address these problems (other professionals, medications, therapies)?

____

____

PREGNANCY HISTORY

Was the mother under the care of a doctor? Yes No

Did the mother take any of the following during pregnancy?

Alcohol Drugs: ______________________

Cigarettes/Nicotine Medications: ______________________

Please check any of the following complications that occurred during the pregnancy:

Difficulty getting pregnant	Infections	Hospitalization required

Bleeding	Diabetes	X Rays

Excessive vomiting	Abnormal weight gain

Other: ____

BIRTH HISTORY

Birth weight: _____ lbs _____ oz	Head Circumference: _______ cm	Length: _____________

Length of pregnancy:	Full term	Post term	Pre term, delivered at _______ weeks

Length of Hospital stay:	Mother: _________________________	Child: ___________________________

Please check any of the following complications:

Forceps used	Breech position	Labor induced

C- Section, due to: ____

Jaundice	Breathing problems	Required Oxygen

Other complications: ____

NICU for _______ weeks; NICU treatments included: ______________________________________

Mother's condition after delivery: ____

CHILD'S MEDICAL HISTORY

Normal hearing evaluation?	Yes, date: __________________	No, ______________________________

Normal vision evaluation?	Yes, date: __________________	No, ______________________________

Immunizations are up-to-date:	Yes	No, missing: ______________________

Last visit to Dentist: _________________________

Has your child ever taken any medications?	Yes	No

If yes please complete following:

Medication Name:	**Dose**	**Dates/ages medication was taken**	**Reason for taking medication**	**Side effects or reason for stopping.**

Please check any of the following medical problems your child has had:

Wears glasses or contact lenses	Asthma	Thyroid problem

Seasonal allergies	Diabetes GERD (Reflux)

Wears hearing aide	Ear infections	Stomachaches

Head injuries	Sinus infections	Constipation

Frequent headaches	Obstructive Sleep Apnea	Diarrhea

Seizures	Dental problems	Weight changes

Vocal or Motor Tics	Heart murmur	Poor appetite

Frequent colds	High blood pressure	Hernia

Eczema	Dislocation	Flat feet
Large birthmarks	Broken bones	Bone pain
Multiple birthmarks	Scoliosis	Pain, location:__________

Surgeries, dates: __________________ Reason: ____

Hospitalization, dates: _____________ Reason: ____

Other: ____

DEVELOPMENTAL HISTORY

Speech Development

Did your child have delays in speech and language milestones?	Yes	No
Do you have any concerns regarding your child's communication skills now?	Yes	No
Has your child ever received Speech Therapy?	Yes	No

Motor Development

Did your child have delays in motor development milestones?	Yes	No
Do you have any concerns regarding your child's motor skills now?	Yes	No
Has your child ever received physical therapy or occupational therapy?	Yes	No

Self-Help/Daily Living Skills

Does your child have any problems with self-help skills (toileting, feeding, bathing, etc.)	Yes	No

Social/Emotional Development

Describe your child's quality of attachment with…

Mother? _______________________________________ Father? _______________________________________

Does your child have difficulty getting along with…

Parents?	Yes	No	Other children?	Yes	No
Siblings?	Yes	No			

Does your child question their gender identity? Yes No

BEHAVIOR HISTORY

Describe your child's personality and general mood: ____

How many tantrums does your child have: ___________ per day ____________ per week

Does your child have aggressive behaviors (hitting, kicking, etc.)? Yes: ____________________ No

What situations or scenarios usually cause your child to have a tantrum or act aggressively? ________________________

____

What types of discipline strategies have you tried to address the above behaviors? ________________________________

____

Has your child's behavior changed or become worse? Yes: ________________________________ No

Does your child have a difficult time following house rules?	Yes	No
Does your child have a problem with lying?	Yes	No
Does your child have a problem with stealing?	Yes	No

Does your child appear anxious or nervous often? Yes No

Does your child have any fears or phobias? Yes: ________________________ No

Does your child seem to have difficulty with concentration/focus? Yes No

Does your child appear more active/impulsive than other children his/her age? Yes No

Does your child have any unusual habits? Yes: ________________________ No

My child **prefers** to play: alone with friends/family enjoys both

Do you have concerns about how your child plays with others? Yes: ____________________ No

SCHOOL HISTORY

Name of School: ______________________________ Grade: ______________

Describe Pre School Experience: ____

Does your child like school? Yes No, because ________________________

Does your child have problems with homework? Yes: ______________________ No

Do you have concerns about your child's learning? Yes: ______________________ No

What do teachers say about your child? ____

Please check any of the following interventions your child has received:

504 Accommodations	RSP	Counseling
Student Study Team (SST)	Speech Therapy	Social Skills
IEP	Occupational Therapy	Small Group Instruction
Psychological evaluation	Physical Therapy	1:1 aide
Special Day Class	Adapted P.E.	Behavioral Support Plan

OTHER SERVICES

Is your child a client of the Regional Center: Yes, and receives: ________________________ No

Is your child receiving therapy through California Children's Services (CCS)? Yes: ______________ No

Is your child receiving any therapies through medical insurance? Yes: ______________________ No

Is your child receiving counseling? Yes: ________________________________ No

SLEEP HISTORY

What time do you put your child in bed? __________ pm

From the time you put your child in bed, how long does it take him/her to fall asleep? ____________________

What does your child do during this time? ____

Does your child share a bedroom with other family members? Yes No

Does your child need another person in the room/bed to fall asleep? Yes No

Is there a TV in your child's bedroom? Yes No

Is the TV on while child is in bed trying to fall asleep? Yes No

In general, does your child sleep through the night? Yes No

Does your child snore? Yes No Occasionally

Please check any of the following problems your child has:

Sleep walking | Grinds teeth | Difficulty falling asleep

Sleep talking | Nightmares/Night Terrors

Sleep apnea (snorting, gasping for air) | Constant leg or body movements

Other ____

Does your child take naps during the day? Yes, from _________ - _________ No

Does your child appear sleepy during the day? Yes No

FAMILY AND SOCIAL HISTORY

Check any of the following your child has been a victim or witness of:

Sexual Abuse | Neglect | Physical Abuse

If yes to any of the above, please explain: ______________________________

Please check any of the following family dynamics that apply:

Parents are separated, date: ________________ | DCFS Referral (past or present), dates: _______

Parents are divorced, date: ________________ | Death: ________________________

Single Parent (other parent not involved) | Traumatic Event: ________________

Adopted child | Moves: ________________________

Foster Care (past or present), date: __________ | Loss: ________________________

If parents are separated or divorced, what is the custody arrangement?

Physical custody: Joint Sole:___________________

Legal custody: Joint Sole:___________________

Visitation schedule/frequency: ____

Please list any individuals currently living in your home:

Name	Age	Relationship to patient	Health problems, if any

Family history of any of the following conditions (check all that apply. Include relationship to patient):

Genetic condition: ________________________ | Developmental Delays: ____________________

Birth defects: ___________________________ | Speech Delays: __________________________

Blindness: ______________________________ | Learning problem: ________________________

Deafness: _______________________________ | ADHD (Attention problem): ________________

Intellectual Disability: ______________________________ | Seizure Disorder: _________________________

Depression: ______________________________

Bipolar Disorder: ________________________

Anxiety Disorder: ________________________

Schizophrenia: __________________________

Systemic Lupus Disease: _________________

Arthritis: _______________________________

Thyroid Disease: ________________________

Fibromyalgia: ___________________________

Migraines: ______________________________

Parkinson's/Tremors/movement disorders: _______________________________________

Menopause starting at 40 years or earlier (50 is normal): _______________________________

Substance Abuse (Alcohol, drugs): __________

Inter-family marriage (common ancestry): _______________________________________

Other Medical Problem: ___________________

Birth Mother's History

Occupation: __________________ Medical Problems: ____________________ Highest grade completed: ____________

Received assistance in school: Yes, ___________________________________ No

Learning problem: Yes, ___________________________________ No

Behavior problem: Yes, ___________________________________ No

Childhood Atmosphere (abuse, illness, etc...): ____

Birth Father's History

Occupation: __________________ Medical Problems: ____________________ Highest grade completed: ____________

Received assistance in school: Yes, ___________________________________ No

Learning problem: Yes, ___________________________________ No

Behavior problem: Yes, ___________________________________ No

Childhood Atmosphere (abuse, illness, etc...): ____

Step, Foster, or Adoptive Mother's History (if applicable)

Occupation: __________________ Medical Problems: ____________________ Highest grade completed: ____________

Received assistance in school: Yes, ___________________________________ No

Learning problem: Yes, ___________________________________ No

Behavior problem: Yes, ___________________________________ No

Childhood Atmosphere (abuse, illness, etc...): ____

Step, Foster, or Adoptive Father's History (if applicable)

Occupation: __________________ Medical Problems: ____________________ Highest grade completed: ____________

Received assistance in school: Yes, ___________________________________ No

Learning problem: Yes, ___________________________________ No

Behavior problem: Yes, ___________________________________ No

Childhood Atmosphere (abuse, illness, etc...): ____

____ ______________________________

Signature of Parent/Guardian who completed this form **Date**

Please return this form in <u>one</u> of the following ways:

1) Email to naguilar@memorialcare.org.

2) Fax to 562-490-9413

3) Mail to:
Stramski Children's Developmental Center
2651 Elm Ave., Suite #205
Long Beach, CA 90806

THANK YOU! WE LOOK FORWARD TO SERVING YOUR FAMILY.