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

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

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NEW PATIENT INTAKE FORM (0-5 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
- ☐ Cigarettes/Nicotine
- ☐ Drugs: _____
- ☐ 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: _____

CHILD'S MEDICAL HISTORY

Normal hearing evaluation? Yes, date: _____ No, _____

Normal vision evaluation? Yes, date: _____ No, _____

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

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
- ☐ Wears hearing aide
- ☐ Head injuries
- ☐ Frequent headaches
- ☐ Seizures
- ☐ Vocal or Motor Tics
- ☐ Frequent colds
- ☐ Asthma
- ☐ Seasonal allergies
- ☐ Ear infections
- ☐ Sinus infections
- ☐ Obstructive Sleep Apnea
- ☐ Dental problems
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Thyroid problem
- ☐ Diabetes GERD (Reflux)
- ☐ Stomachaches
- ☐ Constipation
- ☐ Diarrhea
- ☐ Weight changes
- ☐ Poor appetite
- ☐ Hernia
- ☐ Eczema
- ☐ Large birthmarks
- ☐ Multiple birthmarks
- ☐ Dislocation
- ☐ Broken bones
- ☐ Scoliosis

☐ Flat feet ☐ Bone pain ☐ Pain, location:_____

☐ Surgeries, dates: _____ Reason: _____

☐ Hospitalization, dates: _____ Reason: _____

☐ Other: _____

DEVELOPMENTAL HISTORY

Speech Development

At what ages did your child do the following? (Age at which child is expected to reach milestone is in parentheses.)

_____ Speak first words (1yr)

_____ Several words besides "mama" and "dada" (1yr)

_____ Have 5-7 additional words (18mo)

_____ Speak in 2-3 word sentences (2yrs)

_____ Form long sentences (5yrs)

Can your child follow single-step directions? Yes No

Can your child follow multi-step directions? Yes No

Describe your child's current language skills: _____

Motor Development

At what ages did your child do the following? (Age at which child is expected to reach milestone is in parentheses.)

_____ Roll (3-5mo)

_____ Sit without support (5-7mo)

_____ Crawl (6-8mo)

_____ Walk (11-16mo)

_____ Run (2yrs)

_____ Ride tricycle (3yrs)

_____ Ride bicycle (5-6yrs)

_____ Throw ball overhand (4ys)

Any concerns about your child's motor skills? _____

Self-Help/Daily Living Skills

At what ages did your child do the following? (Age at which child is expected to reach milestone is in parentheses.)

_____ Uses cup without help (1yr)

_____ Use a spoon (1-2yrs)

_____ Use a fork (2-3yrs)

_____ Undress self (2yrs)

_____ Dress self (3yrs)

_____ Unbutton (3yrs)

_____ Button (3yrs)

_____ Tie shoe laces (5yrs)

Any concerns about feeding/eating? Yes, Reason: _____ No

At what age was your child toilet trained for:

Bowel Control Day time: _____ Night Time: _____ Not Yet

Bladder Control Daytime: _____ Night Time: _____ Not Yet

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 lying problem? Yes No

Does your child have a stealing problem? 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 difficulty 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
- ☐ Student Study Team (SST)
- ☐ IEP
- ☐ Psychological evaluation
- ☐ Special Day Class
- ☐ RSP
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Adapted P.E.
- ☐ Counseling
- ☐ Social Skills
- ☐ Small Group Instruction
- ☐ 1:1 aide
- ☐ 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 to 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 mark if your child does any of the following:

- ☐ Sleep walking
- ☐ Sleep talking
- ☐ Grinds teeth
- ☐ Nightmares/Night terrors
- ☐ Difficulty falling asleep
- ☐ 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: _____
- ☐ Parents are divorced, date: _____
- ☐ Single Parent (other parent not involved)
- ☐ Adopted child
- ☐ Foster Care (past or present), date: _____
- ☐ DCFS Referral (past or present), dates: _____
- ☐ Death: _____
- ☐ Traumatic Event: _____
- ☐ Moves: _____
- ☐ 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: _____
- ☐ Birth defects: _____
- ☐ Blindness: _____
- ☐ Deafness: _____
- ☐ Intellectual Disability: _____
- ☐ Developmental Delays: _____
- ☐ Speech Delays: _____
- ☐ Learning problems: _____
- ☐ ADHD (Attention problem): _____
- ☐ 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 COMPLETION

_____ _____

Signature of Parent/Guardian who completed this form Date

Please return this form in one 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.