Pediatric Intake Form

The Pediatric Intake Form can be used with each family entering your care and readministered annually. Individuals with low literacy skills or whose first language is not English may require assistance to complete the form.

SCORING

Reading the Pediatric Intake Form, also known as the Family Psychosocial Screen, as a whole can help the primary care health professional develop a general understanding of the history, functioning, questions, and concerns of each family.

In addition, specific areas of the Pediatric Intake Form can be scored to provide further insight into specific areas of a family's functioning.

PARENTAL DEPRESSION

Under the heading "Family Activities" are three questions that screen for parental depression. A positive response to two or more questions is considered a positive screen. For parents with a positive screen, it may be helpful to explore other symptoms of depression such as changes in appetite, weight, sleep, activities, energy level, and ability to concentrate; feelings of hopelessness; and suicidal ideation (suicidal thoughts) or suicidal intent. Reassuring parents that depression is common is helpful, as is noting the availability of treatment options provided by mental health professionals and the positive prognosis for the treatment of depression. (See Bridge Topic: Parental Depression, p. 303.)

SUBSTANCE USE

Under the heading "Drinking and Drugs" are seven questions that screen for parental substance abuse. A positive response to any of the first six questions is considered a positive screen. Parents with a positive screen should be asked about frequency of substance use and how their substance use affects their family. A physician's advice to quit smoking is often highly effective, but a physician's advice to stop abusing substances may be less so. Refer for further assessment and treatment as indicated.

DOMESTIC VIOLENCE

Under the heading "Family Health Habits" are four questions that screen for domestic violence. A parent who responds positively to any of these questions should receive further assessment and counseling, including exploration of the extent and patterns of violence, and discussion of safety issues for children and adolescents in the home (including gun storage). A parent may need assistance with making an escape plan and should be referred to hotlines or shelters. Health professionals should affirm that domestic violence is wrong but not uncommon. Victims need follow-up visits and ongoing support even if they return to the abuser. Forming a therapeutic relationship centered around the child's safety and well-being is recommended because children and adolescents are at risk for physical abuse in homes where there is domestic violence. (See Bridge Topic: Domestic Violence, p. 227.)

PARENTAL HISTORY OF ABUSE

Under the heading "When You Were a Child" are eight questions that screen for parents' histories of abuse. A background of abuse predisposes parents to disciplinary practices that may be abusive or too permissive. A positive response to any of the first four questions is considered a positive screen. The last four questions help gather additional information about disciplinary techniques and parents' need for counseling or parenting classes. (See Bridge Topic: Child Maltreatment, p. 213.)

SOCIAL SUPPORTS

Under the heading "Help and Support" are questions that screen for social support, a strong factor in reducing life stresses and parenting stresses. Adequate social support helps ensure that parents have appropriate models for parenting practices and disciplinary techniques. If the parent's answers to the first three questions indicate that she has access to fewer than two support persons or that she is less than satisfied with the support she has, the screen is considered positive. Offer referrals to parenting groups, social work services,

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home visitor programs, or community family support services.

The Pediatric Intake Form also assesses a number of other risk factors for developmental and behavior problems. Risk factors include frequent household moves, being a single parent, having three or more children in the home, having less than a high school education, and being unemployed. Scoring four or more risk factors, including having mental health problems and an authoritarian parenting style (observed when parents use commands excessively or are negative and less than responsive to child-initiated interests), is associated with a substantial drop in children's I.Q. and school achievement. In such cases, children should be referred for early stimulation programs such as Head Start or a quality child care or preschool program.

REFERENCES

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Pediatric Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record. Ongoing evaluations of our care may involve chart reviews by qualified persons, but neither your name nor your child's name will ever appear in any reports.

Circle either the word or the letter for your answer where appropriate. Fill in answers where space is provided.

Child's Name _____ Today's Date _____

Are you the child's
A. Mother
B. Father
C. Grandparent
D. Foster parent
E. Other relative
F. Other
G. Self (Are *you* the patient?)

How many times have you moved in the last year?
_____ times

Where is the child living now?
A. House or apartment with family
B. House or apartment with relatives or friends
C. Shelter
D. Other

Besides you, does anyone else take care of the child? If yes, who? _____ Yes No

Has child received health care elsewhere? If yes, what? _____ Yes No

Does the child have any allergies to any medications? If yes, what? _____ Yes No

Has the child received any immunizations? Yes No
Which ones? _____
Where? _____

Has the child ever been hospitalized? Yes No
When? _____
Where? _____
Why? _____

How would you rate this child's health in general?
A. Excellent B. Good C. Fair D. Poor

Do you have any concerns about your child's behavior or development? Yes No
If yes, what? _____
_____

What are your main concerns about your child?
_____
_____

How old are you?
_____ years old

Are you
A. Single
B. Married
C. Separated
D. Divorced
E. Other

What is the highest grade you have completed?
1 2 3 4 5 6 7 8 9 10 11 12 (High School/GED) 13 14 15 16 17 18 19
Some college or vocational school College graduate Postgraduate

FAMILY MEDICAL HISTORY

Do the child's mother, father, or grandparents have any of the following? If yes, who?

Yes No High blood pressure _____
Yes No Diabetes _____
Yes No Lung problems (asthma) _____
Yes No Heart problems _____
Yes No Miscarriages _____
Yes No Learning problems _____
Yes No Nerve problems _____
Yes No Mental illness (depression) _____
Yes No Drinking problems _____
Yes No Drug problems _____
Yes No Other _____

FAMILY HEALTH HABITS

How often does your child use a seatbelt (carseat)?
A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? Yes No
If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? Yes No

In the past year, have you ever felt threatened in your home? Yes No

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you? Yes No

What kind of guns are in your home?
A. Handgun B. Shotgun C. Rifle D. Other_____ E. None

If you have a gun at home, is it locked up? N/A Yes No

Does anyone in your household smoke? Yes No

Do you currently smoke cigarettes? If yes, how many cigarettes do you smoke per day? Yes No

_____cigarettes/day

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DRINKING AND DRUGS

In the past year have you ever had a drinking problem? Yes No

Have you tried to cut down on alcohol in the past year? Yes No

How many drinks does it take for you to get high or get a buzz? 1 2 3 4 5 6 7 or more

Do you ever have five or more drinks at one time? Yes No

Have you ever had a drug problem? Yes No

Have you used any drugs in the last 24 hours? Yes No
If yes, which one(s)
Cocaine Heroin Methadone Speed Marijuana Other:

_____

Are you in a drug or alcohol recovery program now? If yes, which one(s) Yes No

_____

Would you like to talk with other parents who are dealing with alcohol or drug problems? Yes No

WHEN YOU WERE A CHILD

Did either parent have a drug or alcohol problem? Yes No

Were you raised part or all of the time by foster parents or relatives (other than your parents)? Yes No

How often did your parents ground you or put you in time out?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often did your parents ridicule you in front of friends or family?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often were you hit with an object such as a belt, board, hairbrush, stick, or cord?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often were you thrown against walls or down stairs?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

Do you feel you were physically abused? Yes No

Do you feel you were neglected? Yes No

Do you feel you were hurt in a sexual way? Yes No

Did your parents ever hurt you when they were out of control? Yes No

Are you ever afraid you might lose control and hurt your child? Yes No

Would you like more information about free parenting programs, parent hotlines, or respite care? Yes No

Would you like information about birth control or family planning? Yes No

FAMILY ACTIVITIES

How strong are your family's religious beliefs or practices?
A. Very strong B. Moderately strong C. Not strong D. N/A

Do you have a religious affiliation? If so, what is your religion?

_____

How often do you read bedtime stories to your child?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often does your family eat meals together?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

What does your family do together for fun?

_____

How often in the last week have you felt depressed?
0 1–2 3–4 5–7 days

In the past year, have you had two weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed? Yes No

Have you had two or more years in your life when you felt depressed or sad most days, even if you felt OK sometimes? Yes No

HELP AND SUPPORT

Whom can you count on to be dependable when you need help (just write their initials and their relationship to you):
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Who accepts you totally, including both your best and worst points?
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Whom do you feel truly loves you deeply?
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

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