DOWN SYNDROME PROGRAM INTAKE FORM
ANNUAL REVIEW

FULL NAME _____ **DATE OF BIRTH** _____

Check the preferred way for family to be contacted: by home phone ___ by cell ___ by email ___

What are your biggest concerns about your child today?

1. _____ 2. _____
3. _____ 4. _____

What do you feel are your child's biggest strengths at this time?

1. _____ 2._____
3 _____ 4. _____

Current Medications:

Please list all CURRENT medications, over-the-counter medicines, supplements, or natural products.

Name	**Amount (in milligrams)**	**How often?**	**Date first begun**
(e.g., levothyroxine)	***25 micrograms***	***daily***	***2/1/10***

Additional Medical History: (briefly describe all that apply to your son or daughter)

Hospitalizations: number of inpatient hospitalizations ( ) Surgeries: _____

Serious Illnesses: _____ Accidents/Injuries: _____

Allergies to Medications: _____ Other Allergies: _____

Allergy Testing: Yes No When: _____ Results: _____

Equipment:

Does your child use any assistive devices or special equipment on a daily basis? (e.g. glasses, hearing aides, augmentative communication devices, etc) ☐YES ☐NO If yes, please provide details _____

Immunizations:

Are your child's immunizations up to date? ☐YES ☐NO Did your child receive the flu shot this past year? ☐YES ☐NO

Sibling Information: list names, ages and any medical/behavior/educational concerns

1. _____
2. _____
3. _____
4. _____

Family Medical History: List family members with any of the conditions listed (e.g. maternal grandmother)

CONDITION	FAMILY MEMBER
down syndrome	
diabetes	
celiac disease	
high blood pressure	
high cholesterol	
thyroid disease	
arthritis	
heart disease	
seizures	
stroke	
dementia/alzheimer's disease	
cancer (_____)	
mental health (_____)	
obstructive sleep apnea	
other	

SLEEP: n/a ☐ Please check the boxes below if your child has any of the following:

☐ Snore? ☐ Use multiple pillows?

☐ Have morning headaches? ☐ Gasp, snort, choke during sleep?

☐ Sleep with neck hyper-extended? ☐ Open mouth during sleep?

☐ Significant weight gain? ☐ Wet the bed?

☐ Night terrors? ☐ Sleep walk?

☐ Sleep talk? ☐ Sleep upright?

☐ Sleep folded over? ☐ Other? _____

Changes in school performance or behavior concurrent to weight gain and/or onset of sleep disturbances? ☐

Does your child not seem refreshed despite getting an adequate amount of sleep? ☐

Does your child fall asleep in the car on short drives, at school, or nap in an age inappropriate way? ☐

REVIEW OF SYSTEMS Please CIRCLE any concerns & add specialist if applicable OR check N/A if not applicable

General Information:

Concerning weight change Fever
Increasing fatigue New behavior issues

Toilet Training: n/a ☐

Full trained Constipation
Accidents with urine Accidents with stool
Other:

GI: n/a ☐
specialist _____ last visit_____

Stomach complaints constipation Vomiting
Nausea underweight diarrhea
Reflux overweight other:

Genito-Urinary: n/a ☐
specialist _____last visit _____

urinary tract infections kidney problems
other

Feeding/Swallowing: n/a ☐

Trouble eating food choking/gagging with liquids
Trouble drinking liquids choking/gagging with food
Aspiration special dietary needs
Other:

Cardiac: n/a ☐
specialist _____last visit _____

Murmur sweating when feeding
Chest pain poor exercise tolerance
High blood pressure other:

Respiratory n/a ☐
Specialist _____last visit_____

Pneumonia Wheezing/asthma
Difficulty breathing Other:

Allergy/Immunology: n/a ☐
Specialist _____last visit _____

Seasonal allergies Allergy to food
New autoimmune diagnosis (ex. alopecia) Other:

Ear, Nose, Throat: n/a ☐
Specialist _____last visit _____

Ear infections sinus problems
Wax build up tympanostomy tubes
Hearing loss frequent runny nose
Hearing aids frequent sore throat
Other:
Date/results of last hearing screen?_____

Endocrine: n/a ☐
Specialist _____last visit_____

Excessive thirst diabetes
Too hot urinates frequently
Too cold hyperthyroidism
Tired/sluggish hypothyroidism
Other:
Date/results of last thyroid screen?_____

Neurologic: n/a ☐
Specialist _____last visit_____

Seizures
Abnormal movements
Not able to do things as used to
Weakness
Change in bladder function
Change in bowel function
Other:

Musculoskeletal: n/a ☐
Specialist _____last visit _____

Neck pain joint problems
Abnormal head position difficulty walking
Atlantoaxial instability fall frequently
Wears braces head tilt
Scoliosis new onset weakness
Morning stiffness change in use of arms/legs
Other:

Eyes: n/a ☐
Specialist _____last visit _____

Concerns about vision Lazy eye
Cataracts Wears glasses or contacts
Other:

Dental: n/a ☐
Specialist _____last visit _____

Gum disease difficulty brushing Gum problem
braces Cavities retainer
Other:

Hematologic: n/a ☐
Specialist _____last visit _____

Anemia TMD (transient myeloproliferative disorder)
Leukemia Other:

Skin: n/a ☐
Specialist _____last visit _____

Rash excema
Dry skin alopecia/hair loss
Other:

FOR MALE PATIENTS n/a ☐

Undescended testicles hernia

FOR FEMALE PATIENTS n/a ☐

Period started YES began when _____
How often and for how long _____
Has she ever had a pap smear? YES if yes date _____
Has her PAP ever been abnormal? YES NO
Is birth control needed? YES NO

Do you have an estate plan for your child? YES NO

Do you have any social or financial needs regarding support for your child or family? YES NO

_____

Would you like to speak with a social worker from Children's Hospital Boston about your needs? YES NO

Recreation: Does your child participate in a form of exercise on a regular basis? YES NO

Does your child participate in any social or recreation programs outside of school? YES NO

Please list activities: _____

Education: Is your child in school? YES NO Name of School _____

Grade _____ Placement Type is: (please circle) inclusion partial inclusion substantially separate homeschool

Other? _____

Do you feel your IEP is currently meeting your son's or daughter's needs? YES NO

_____

Does your son or daughter receive any special supports or services: YES NO

_____

Does your son or daughter attend an after-school program? YES NO

_____

Does your son or daughter receive any educational supports, therapy, or programs outside of the school setting? YES NO

_____

Does your son or daughter participate in any school related groups, teams, or activities? YES NO

_____

Extra Supports:

Name of Organization	We are connected	I would like more information
Massachusetts Down Syndrome Congress	☐YES ☐NO	☐YES ☐NO
Supplemental Security Income (SSI)	☐YES ☐NO	☐YES ☐NO
Masshealth/Commonhealth	☐YES ☐NO	☐YES ☐NO
Dept. of Developmental Disabilities (formerly known as DMR)	☐YES ☐NO	☐YES ☐NO
National Down Syndrome Congress, National Down Syndrome Society	☐YES ☐NO	☐YES ☐NO
Federation for Children with Special Needs	☐YES ☐NO	☐YES ☐NO
The ARC	☐YES ☐NO	☐YES ☐NO
Special Olympics	☐YES ☐NO	☐YES ☐NO
Local Support Groups	☐YES ☐NO	☐YES ☐NO