DOWN SYNDROME PROGRAM INTAKE FORM
NEW CHILD

FULL NAME _____**DATE OF BIRTH** _____

Street Address _____Apt _____City _____

State _____ Zip Code _____ Home Phone _____Gender _____

Parent Name _____ Parent's occupation/place of work: _____

Parent Cell _____Parent Email _____

Parent Name _____ Parent's occupation/place of work: _____

Parent Cell _____ Parent Email _____

If applicable: Legal Guardian _____ Son or Daughter lives with _____Step-parents _____

Primary Language(s) spoken at home _____ Interpreter needed for visit? If yes, what language? _____

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

Pediatrician Information:

Pediatrician Name _____Practice Name _____

Office Phone _____Office Fax _____

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. _____

Birth History:

Birth Hospital _____Type of Delivery? ☐Vaginal ☐ Planned C-Section ☐Emergency C-Section

Length of Infant's Hospitalization _____ Delivered at ____ weeks gestation. Mother's Age at Delivery _____

Birth Weight _____ Birth Length _____ Head Circumference _____ Apgar Scores _____

How many times has mother been pregnant? _____ How many children does mother have? ____

Diagnosis:

Diagnosis received? ☐ PRENATAL ☐ POSTNATAL If prenatal, how? ☐ amniocentesis ☐ CVS ☐ Early Screening

Were chromosome studies done? ☐YES ☐NO Did you receive results? ☐YES ☐NO

Who discussed these results with you? _____ Diagnosis? ☐ Trisomy 21 ☐Mosaic ☐Translocation ☐ Not Sure

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 Annual Flu Shot? ☐YES ☐NO

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	

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

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

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?
☐ Wet the bed ☐ Night terrors? ☐ Sleep walk ☐ Sleep talk?
☐ Sleep upright? ☐ Open mouth during sleep? ☐ Sleep with neck hyper-extended? ☐ 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? ☐

Do you have any concerns for your child around safety? If so, please describe:

_____
_____
_____
_____
_____
_____

Do you have any concerns regarding behavior for your child? If so, please describe:

_____
_____
_____
_____
_____
_____

Please share any other information or concerns you have about your child:

_____
_____
_____
_____
_____
_____

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

Social:

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

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

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	Connected?	Want more info?	Name of Organization	Connected?	Want more info?
Massachusetts Down Syndrome Congress	☐YES	☐YES	Dept of Developmental Disabilities	☐YES	☐YES
Supplemental Security Income (SSI)	☐YES	☐YES	National Down Syndrome Congress	☐YES	☐YES
Masshealth/Commonhealth	☐YES	☐YES	National Down Syndrome Society	☐YES	☐YES
The ARC	☐YES	☐YES	Federations for Children with Special Needs	☐YES	☐YES
Local support groups	☐YES	☐YES	Special Olympics	☐YES	☐YES