ADVANCED HEALTH & PERFORMANCE INSTITUTE

DR. PHILLIPS/WINDERMERE OFFICE
6735 CONROY-WINDERMERE ROAD
SUITE 309, ORLANDO, FL 32835

EVALUATION INTAKE FORM

To help us better customize our program to your family's personal needs and provide the smoothest experience we ask that you please fill out the following form:

Your/Child's Personal Information:

Today's Date: _____
Child's Name: _____
M F
Age: _____
Birthdate: _____

Current Concerns About You or Your Child:

- Aggression
- Overactivity
- Preoccupations
- Hitting
- Argumentative
- Motor Skills
- School adjustment
- Temper tantrums
- Wets the bed
- Won't take baths
- Language difficulties
- Self-injury
- Nightmares
- Easily Distracted
- Appetite/food selections
- Depressed or Anxious
- Toilet training
- Biting
- Sleep problems
- Nervousness
- Self-help skills
- Inattentive
- Self-stimulatory behaviors
- Other

Please provide detail for any of the items checked above:

_____
_____
_____
_____

Dr. Phillips/Windermere Office
6735 Conroy-Windermere Road
Suite 309, Orlando, FL 32835

What is the biggest problem?

How long has it been a problem?

What do you think caused it?

What seems to upset the child?

What seems to calm the child?

DEVELOPMENTAL HISTORY

Early childhood history:
During your child's first three years, were any special problems noted in the following areas?

- Irritability
- Difficulty sleeping
- Failure to thrive
- Poor eye contact
- Convulsions/Seizures
- Breathing problems
- Eating problems
- Excessive Crying
- Early learning problems
- Twitching
- Colic
- Temper tantrums
- Withdrawn behavior
- Destructive behavior
- Unable to separate from parent
- Other

Can child be described as clumsy/uncoordinated? Yes No
Fine motor delay? Yes No
Current eating behavior:
Normal _____ Picky _____ Eats too much _____ Weight loss/gain _____

Dr. Phillips/Windermere Office
6735 Conroy-Windermere Road
Suite 309, Orlando, FL 32835

Oral Motor Concerns:

None _____ Difficulty Swallowing _____ Drooling _____ Gagging_____

MEDICAL HISTORY

Has your child ever had:

Head Injury? _____ Age _____ Describe _____
Loss of consciousness? _____ Age _____ How long? _____
Describe
_____
_____
_____
_____
_____
_____

Allergies to food/medication? _____

List:
_____
_____
_____
_____

Can you/your child swallow pills?_____

Surgery? _____ Age _____ Reason _____ Describe _____
(if more than one surgery, please list on back)

Immunizations: When did you stop immunizing and what immunizations have they had. What was the reason you stopped or did not start vaccinations?
_____
_____
_____

Dr. Phillips/Windermere Office
6735 Conroy-Windermere Road
Suite 309, Orlando, FL 32835

Doctors Seen:

Pediatrician: _____ Diagnosis:
Neurologist: - Date: _____Diagnosis
Suspected seizures, describe: _____
Diagnosed seizures, type: _____

Genetics – Date: _____ Diagnosis:
Psychiatry – Date: _____ Diagnosis:
Gastroenterology – Date: _____ Diagnosis:
Stomach/intestinal problems, type: _____
Endocrinology – Date: _____

Diagnostic Testing: (check all that apply)

- EEG (brain wave test) – Date: _____ Results:
- MRI – Date: _____ Results:
- CT Scan – Date: _____ Results:
- Chromosomal/DNA testing (Genetics) – Date: _____
- Other – Describe: _____

Medication/Supplement History:
Current medications/supplements (Please note: DO CONTINUE TO ADMINISTER child's regularly scheduled medications, if any, on the day of your brainmap appointment.)

Name of medication and or supplements	Dose & Frequency	Date Started	Reason	Effectiveness

Dr. Phillips/Windermere Office
6735 Conroy-Windermere Road
Suite 309, Orlando, FL 32835

_____
_____

Who prescribed these medications? _____

Please also list any medications your child has been on in the PAST:

Name of medication Dose & Frequency Date Started Reason Effectiveness

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Who prescribed these medications? _____

CHECKLIST:

Please mark any of the following in each area that describe your child currently or in the past.

SPEECH:

Slow speech development
Unusual tone or pitch
Difficult to understand speech
Seldom speaks unless prompted
Has own language
Doesn't understand without gestures

Dr. Phillips/Windermere Office
6735 Conroy-Windermere Road
Suite 309, Orlando, FL 32835

Repeats words/phrases, questions or dialogue over and over

RELATING WITH OTHER PEOPLE:

Prefers to be by self
Aloof, distant
Fearful of strangers
Doesn't like to be held
Doesn't play with other children
Prefers playing with younger or older children
"in a world of his/her own'
Clings to people
Doesn't recognize parent

IMITATION:

Doesn't imitate waving "bye" etc (Physical imitation)
Doesn't repeat words/things said to him
Doesn't repeat words generally, but will usually do what he/she is asked

RESPONSE TO SOUNDS, SPEECH:

Often ignores sounds
Afraid of certain sounds
Often ignores what is said to him/her
Really likes certain sounds
Seems to hear distant or soft sounds that most other people don't hear or notice
Unpredictable response to sounds (sometimes reacts, sometimes doesn't)
Responds to speech and sounds like other children of the same age

VISUAL RESPONSE:

Stares vacantly around room
Often doesn't look at things
Likes to look at self in mirror
Likes to look at shiny objects
Stares at parts of his/her body (e.g. hands)
Often avoids looking at people when they are talking to him
Distracted by lights- stares at certain lights
Very interested in small parts of an object
Looks at things out of the corners of eyes

Dr. Phillips/Windermere Office
6735 Conroy-Windermere Road
Suite 309, Orlando, FL 32835

OTHER SENSES:

Puts many objects in mouth
Licks objects
Overreacts to pain
Chew or eats objects that are not supposed to be eaten
Likes vibrations
Doesn't notice pain as much as most people
Smells unusual or unfamiliar objects

EMOTIONAL RESPONSES:

Temper tantrums
Overly responds to situations
Cries/seems sad for no obvious reason
Little response to what is happening around him/her
Laughs/smiles for no obvious reason
Moods change quickly/for no apparent reason
Often has blank expression on face

SERVICES- Please list services your child has received.

Which services is your child CURRENTLY receiving?

- Speech Therapy _____
- Adaptive Physical Education _____
- Occupational Therapy _____
- Physical Therapy _____
- Social Skills _____
- ABA Therapy: _____
- Other: _____

PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT