

Ventura County Early Start Program

EARLY START INTAKE INTERVIEW WORKSHEET

Date of Report: _____		
Dual case: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name: _____	UCI: _____	DOB: _____

IDENTIFYING INFORMATION:

Age: _____ Sex: M F Ethnicity: _____

Address: _____

Phone Number: _____ Legal Status: _____

Who does the child reside with? _____ Natural Parents: Yes No _____

Foster Parents: Yes No _____ CPS Worker: Yes No _____

By whom referred: _____

Risk Factors: _____

Reason for concern (*congenital anomalies, prematurity, diagnosis, etc.*): _____

Location of interview: _____

Persons attending intake: _____

Health Insurance: _____

FAMILY SITUATION:

Mother: _____ Maiden Name: _____ DOB: _____

Age: _____ Educational Background _____ Degree: _____

Vocation: _____

History of disabilities (*i.e. learning, special needs, CP, autism, etc.*): _____

Father: _____ DOB: _____ Age: _____

Educational Background _____ Degree: _____

Vocation: _____

History of disabilities (*i.e. learning, special needs, CP, autism, etc.*): _____

Sibling's Name: _____ DOB: _____ Age: _____

Education: _____ Where does sibling reside? _____

Sibling's Name: _____ DOB: _____ Age: _____

Education: _____ Where does sibling reside? _____

Sibling's Name: _____ DOB: _____ Age: _____

Education: _____ Where does sibling reside? _____

MOTHER'S PRENATAL HISTORY:

Mother's medical history

Mom's health during pregnancy: _____

Due Date: _____ Maternal age at time of birth: _____ Prenatal Care: Yes No

At what month received: _____ Who provided care: _____

Problems during pregnancy

- | | | | |
|--|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chronic Disease | <input type="checkbox"/> Rh Incompatibility | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Viral Infection | <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> UTI | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Other | |

Comments: _____

Substance exposure

One month prior- What was your use of alcohol? _____

What was your use of tobacco? _____

What was your use of recreational drugs? _____

What was your use of prescriptions? _____

During pregnancy- What was your use of alcohol? _____

What was your use of tobacco? _____

What was your use of recreational drugs? _____

What was your use of prescriptions? _____

What was your use of prenatals/folic acid/iron? _____

BIRTH HISTORY:

Fetal Movement: _____ At what month: _____

Hospital of birth: _____ Length of labor: _____

Gestational Age (<32 weeks): _____

Apgars (5 minutes between 0-5): _____ 1 minute _____ 5 minutes _____ 10 minutes

Birth Weight (1500 grms/3 lbs 5 oz): _____ Length: _____

Delivery

- | | | | |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> C-Section | <input type="checkbox"/> Induced Labor | <input type="checkbox"/> Premature (_____ weeks) |
| <input type="checkbox"/> Breech | <input type="checkbox"/> Jaundiced | <input type="checkbox"/> Cord Around Neck | <input type="checkbox"/> Transfused |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Twin (1 st or 2 nd) | <input type="checkbox"/> Rh-incompatible | <input type="checkbox"/> Baby Rotated |
| <input type="checkbox"/> Transverse | <input type="checkbox"/> Abrupton | <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Meconium Aspiration/Stained |
| <input type="checkbox"/> Other | Comments: _____ | | |

NURSERY COURSE:

Regular nursery course: _____ NICU: _____

Transport to other hospital: Yes No Name: _____

Reason: _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Oxygen/Ventilator | <input type="checkbox"/> Respiratory Distress Syndrome | <input type="checkbox"/> Bronchio-Pulmonary Disease | <input type="checkbox"/> Apnea and Bradycardia |
| <input type="checkbox"/> Intracranial Hemorrhage (grade): _____ | | <input type="checkbox"/> Other: _____ | |

Surgeries: Yes No Seizures: Yes No Congenital Anomalies: Yes No

Patent Ductus Arteriosus: Yes No Retinopathy of Prematurity: Yes No Genetic Syndrome: Yes No

Comments: _____

HOSPITAL STAY:

Length of stay- Mom: _____ Baby: _____

Equipment Needed: _____ Tube/Gavage Feedings: _____

Test/Evaluation: _____

Discharge instructions (equipment, medication, etc.):

Comments: _____

BABY/CHILD CURRENT STATUS:

Current Health: _____ Current Weight: _____ Height: _____

Vitamins: Yes No Medications: Yes No Type: _____ Dosage/Frequency: _____

Reason: _____ Dr. who prescribed medications: _____

MEDICAL FOLLOW UP:

Pediatrician: _____ Last Visit: _____ Next: _____

Specialist: _____ Appointment: _____

Specialist: _____ Appointment: _____

Follow-up Clinic: _____

Immunizations Up-to-Date: Yes No Explain: _____

Medical problems

Tone Issues: Hypo? Hyper? Upper Extremities Lower Extremities

Re-hospitalizations: Yes No What Hospital: _____

Length of each: _____

Illness: _____ Surgeries: _____ Seizures: _____ Allergies: _____

Nutrition

Breast Feeding: Yes No How Much: _____ How Often: _____

Formula: Yes No Which: _____ How Much: _____ How Often: _____

Other Foods/Supplements (*types, amount, frequency*): _____

How Often: _____

Hearing

Formal hearing evaluation: Yes No When: _____ Where: _____

Results: _____

Referred to Hearing Conservation: (805) 388-4438 on _____

Vision

Formal vision evaluation: Yes No When: _____ Where: _____

Results: _____

Referred to: _____

Adaptive equipment

Yes No Reason: _____ Type: _____

Comments: _____

OTHER AGENCIES INVOLVED:

WIC: Yes No Medi-cal: Yes No CPS: Yes No SSI: Yes No CCS: Yes No
Other: _____

ADVANCED SCREENING:

Sensory issues

Is s/he sensitive to: Sounds: Yes No Touch: Yes No Brightness: Yes No

Other: _____

Regulation issues

Daily Schedule: Sleeping (*including naps*) _____

Eating: Picky Eater Yes No How Often: _____ Size of Serving: _____

Transition issues

Does s/he have difficulty with changes?: People: Yes No Places: Yes No

Daily Schedule: Yes No Going from one activity to the next: Yes No

Attention

Is s/he: Over focused on one thing at a time: Yes No Not able to focus: Yes No

Other: _____

Behavior issues (*consider age appropriateness and extent and frequency of behavior*)

Is s/he: Too Passive: Yes No Overwhelmed: Yes No Easily Upset: Yes No

Angers Quickly: Yes No Bites, Pinches others: Yes No Screams: Yes No

Throws Things: Yes No Excessive Irritability: Yes No