

**CLIENT INTERVIEW FORM—BIRTH TRAUMA**

Information Taken by: \_\_\_\_\_

Date: \_\_\_\_\_

**GENERAL BACKGROUND INFORMATION**

Child's Name: \_ \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Mother's Name: \_ \_\_\_\_\_

Address: \_ \_\_\_\_\_

Telephone No: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Occupation: \_ \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address: \_ \_\_\_\_\_

Telephone No: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Occupation: \_ \_\_\_\_\_

Other Children:

Name	Date of Birth	Age

## MOTHER'S MEDICAL HISTORY

Yes	No	
		• Hypertension
		• Diabetes:
		• Insulin dependent
		• Cardiac disease
		• Pulmonary disease (i.e., asthma, TB)
		• Renal disease
		• Throid dysfunction
		• Seizure disorders
		• Rh Negative
		• Blood transfusions
		• Silicone implants
		• Was accutane ever taken?
		• Other medical conditions (i.e., rheumatoid arthritis, cancer, gastrointestinal or skin disorders, etc.)

If your answer was yes to any of the above, please specify how it affected pregnancy. How was it treated?

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**Obstetrical History:** Problems during previous or subsequent pregnancies. If your answer is yes, insert the number of times.

Yes	No		# of Times
		• Total number of pregnancies	
		• Uterine or cervical abnormalities	
		• Abortions	
		• Miscarriages	
		• Stillborn	
		• Post neonatal death	
		• Prematurity	
		• Fetal distress	
		• SGA (small for gestational age)	
		• Birth weight greater than 9 lbs.	
		• C/Section	
If yes, why? _____			
_____			


- Infertility
- Fertility drugs taken
- Donor fertilization
- Multiple birth
- Child with developmental delays
- Child with mental retardation
- Child with congenital abnormalities
- Child with hereditary disease
- In vitro fertilization/ artificial insemination


If your answer was "yes" to any of the above questions, please elaborate.

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**Subject Pregnancy:**

Yes	No

- Working during pregnancy? Occupation: \_\_\_\_\_
- Pre-natal vitamins
- Fertility drugs taken
- In vitro fertilization
- Artificial insemination
- Donor semination
- Any problems with infertility?
- L.M.P.: \_ \_\_\_\_\_
- Due Date: \_ \_\_\_\_\_
- Total Weight Gain: \_\_\_\_\_
- Gestation age at first prenatal visit: \_\_\_\_\_
- Frequency of prenatal visits: \_\_\_\_\_
- Physician or midwife's name: \_\_\_\_\_

**Substance Use/Exposure During Subject Pregnancy:**

Yes	No

- Smoking
- Caffeine
- Alcohol
- Narcotics
- Marijuana/Cocaine
- IV Drug Use
- Prescription Drugs/Medications
- Over-the-counter drugs
- Any unusual exposures during pregnancy (i.e., x-rays, pesticides,
- Animal exposure

**CHILD'S MEDICAL HISTORY**

**Newborn Birth History:**

Yes No


- At birth was child observed to be "blue" or "dusky"?
- At birth was child observed to be "pink"?
- Did child begin to breath spontaneously?
- Was help required by physician or nurse to begin breathing?
- If help was needed, which of the following was provided:


- Oxygen
- Resuscitation by face mask
- Cardiac massage/pressure
- Intubation

- If meconium was present in amniotic fluid, was intubation into
- What were the Apgar scores?


- What was the birth weight?
- What was the birth length?
- What was the head circumference?

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- Once born, did the child experience breathing difficulties? If yes, please specify: \_\_\_\_\_

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- Were birth defects noted following birth? If yes, please specify: \_\_\_\_\_


- Was child sent to a regular nursery?
- At any time was child transferred to an intensive care unit? If yes, please specify: \_\_\_\_\_

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- During initial nursery stay did any of the following occur:
  - "Low" body temperature? If yes, please specify: \_\_\_\_\_

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- "Blue" spells? If yes, please specify: \_\_\_\_\_

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- Low blood sugar? If yes, please specify: \_\_\_\_\_

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- Feeding Problems? If yes, please specify: \_\_\_\_\_

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- Choking or vomiting episodes? If yes, please specify: \_\_\_\_\_

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- Jaundice? If yes, please specify: \_\_\_\_\_

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- Was PKU blood test performed before discharge?  
If yes, please specify: \_\_\_\_\_

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- Were any unusual tests or x-rays performed (blood tests, cultures, spinal tap)? If yes, please specify: \_\_\_\_\_

**CHILD'S CURRENT CONDITION**

Current Age: \_\_\_\_\_

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Does the child have a disability? Diagnosis rendered:</li> <li>• Diagnosis Rendered: _ _____</li> <li>• At what age was this disability noted? _____</li> <li>• Describe the extent of disability by indicating if any of the following are present:</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Mental retardation</li> <li>• Seizure disorder</li> <li>• Cerebral palsy                             <ul style="list-style-type: none"> <li>• If cerebral palsy is present, is head control involved?</li> <li>• Is spasticity one-sided?</li> <li>• Does spasticity involve both sides of the body?</li> <li>• Are arms more involved than legs?</li> </ul> </li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Is there a delay in speech or language? If yes, please specify: _____</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Is there a problem with communicating to others? If yes, please specify: _ _____</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Is there a problem relating to other children? If yes, please specify: _ _____</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Does the child experience rage or unmanageability? If yes, please specify: _ _____</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Does child experience any problems with motor skills and coordination, rolling over, crawling, sitting, standing, tying shoes, etc.? If yes, please specify: _____</li> </ul>

Is there a problem with any of the following areas? If yes, please specify:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	• Hearing
<input type="checkbox"/>	<input type="checkbox"/>	• Vision
<input type="checkbox"/>	<input type="checkbox"/>	• Feeding
<input type="checkbox"/>	<input type="checkbox"/>	• Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	• Breathing
<input type="checkbox"/>	<input type="checkbox"/>	• Bowel function
<input type="checkbox"/>	<input type="checkbox"/>	• Urine function
<input type="checkbox"/>	<input type="checkbox"/>	• Sleeping
<input type="checkbox"/>	<input type="checkbox"/>	• Coordination/motor control

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