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?

_____

_____

_____

_____

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 abnomalities	
		• 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.

_____

_____

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?
		• Once born, did the child experience breathing difficulties? If yes, please specify: _____
		• 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: _____
		• During initial nursery stay did any of the following occur:
		• "Low" body temperature? If yes, please specify: _____ _____
		• "Blue" spells? If yes, please specify: _____ _____
		• Low blood sugar? If yes, please specify: _____ _____
		• Feeding Problems? If yes, please specify: _____ _____
		• Choking or vimiting episodes? If yes, please specify: _____
		• Janudice? If yes, please specify: _____ _____
		• Was PKU blood test performed before discharge? If yes, please specify: _____
		• 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	
		• Does the child have a disability? Diagnosis rendered:
		• Diagnosis Rendered: _ _____
		• At what age was this disability noted? _____
		• Describe the extent of disability by indicating if any of the following are present:
		• Mental retardation
		• Seizure disorder
		• Cerebral palsy
		• If cerebral palsy is present, is head control involved?
		• Is spaticity one-sided?
		• Does spasticity involve both sides of the body?
		• Are arms more involved than legs?
		• Is there a delay in speech or language? If yes, please specify: _____
		• Is there a problem with communicating to others? If yes, please specify: _ _____
		• Is there a problem relating to other children? If yes, please specify: _ _____
		• Does the child experience rage or unmanageability? If yes, please specify: _ _____
		• Does child experience any problems with motor skills and coordination, rolling over, crawling, sitting, standing, tying shoes, etc.? If yes, please specify: _____ _____

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

Yes	No	
		• Hearing
		• Vision
		• Feeding
		• Swallowing
		• Breathing
		• Bowel function
		• Urine function
		• Sleeping
		• Coordination/motor control

_____
_____
_____