Developmental Pediatric Specialists

PROMOTING CHILD DEVELOPMENT AND SUCCESS

Please help us to understand your child better by completing the following form.

Child's Name: ___________________________________

Date of Birth: ____________

Name/relation of person filling out form: ______________________________

Referral source: ____

Reason for evaluation:

When and why did you first become concerned about your child?

What would you like to learn from the evaluation?

Family History
Please list the names, ages, and occupations, of all persons living in the home (include parents, siblings, and relatives)

Name	Age	Relationship	Occupation
1.			
2.			
3.			
4.			
5.			

Family History- Has anyone in the family or extended family of either parent had any medical, neurological, development, learning behavioral or psychiatric conditions? Please list the relationships and conditions:

Pregnancy

Number of pregnancies: _________

History of previous
pregnancies:____

Were there any complications during this pregnancy: ____________________________

Birth History

Delivery: Vaginal: _____ C-Section: ______

Gestational Age: _______Birth Weight: ________ Length: ___________

Were there any complications during this delivery: ______________________________

____

Complications/Treatments after birth: _________________________________

____

Length of stay in hospital: ____

Developmental History:
Describe your child's temperament as an infant (i.e. contented, happy, colicky, irritable, fussy, good sleeper, not good sleeper, feeding difficulties, breast fed or bottle fed, resistance to being held/cuddled, desire to be held/carried/bounced/rocked, etc.):

Clinical Notes:

Did your child smile as a young infant (3+ months)? Yes ____ No ______

Make eye contact?: Yes ____ No _____

At what age did your child:

Sit:_______   Crawl:_______   Walk:____________

Did your child babble prior to speaking? Yes____ No____

Say first word: _______What was first word?___________ Say two words together:__________

Speech Progress: Advanced: ____ Typical: ____ Delayed: ____ Significantly Delayed:____

Did your child have any feeding difficulties **in infancy**? (please explain)

<u>Current Development</u>

Motor Skills:
Gross Motor - Any difficulties noted in your child's motor skills such as walking, running, jumping, climbing, bike riding, kicking/throwing/catching balls, motor coordination, frequent stumbles/falls (please circle and/or describe difficulties)?

Fine Motor – Any difficulties eating with utensils, holding writing instruments, writing, cutting with scissors, picking up objects, holding objects, fastening buttons, snaps, zippers, tying shoes (please circle and/or describe difficulties)?

Clinical Notes:

Cognitive/Learning:

Daycare: ______ Preschool: ______ School: _____ Grade: ______

Name of Daycare/Preschool/School: ________________________________

Is your child able to:

- Learn and/or retain information: Yes ____ No _____
- Focus/maintain attention/complete tasks: Yes ___ No ___
- Perform at grade level: Yes ___ No ____
- Follow directions: Yes ____ No ______
- Stay seated and participate in classroom activities: Yes ____ No ____

If "No", please explain:

Does your child have an IEP (Individualized Education Plan)? Yes ___ No ____

Services/Accommodations offered through IEP:

Clinical Notes:

Behavior:

Do you have any concerns regarding your child's behavior? (If so, please explain.)

Please describe a good day for your child:

Please describe a bad day for your child

Does your child's behavior affect his or her ability to interact/socialize/communicate?

Yes _____ No _____

If "Yes", please explain:

Does your child have difficulty with transitioning from one activity/location to another?

Yes _____ No _______ If "Yes", please explain:

Is your child disturbed by changes in routine? Yes_____ No ______

If "Yes", please explain:

Clinical Notes:

Social:

How does your child relate to you, other family members, other children, teachers, etc.?

Do you have any concerns regarding the way your child socializes?

Tell us about your child's friends.

Does your child seem to gravitate towards one age group more than another?

Communication:

Do you have any concerns about your child's ability to communicate?

Does your child speak in/with:

- Complete sentences? Yes ____ No _____
- 2-3 word phrases? Yes _____ No _____
- 1-word utterances? Yes _____ No _____
- Communicative intent? Yes _____ No _____

Does your child have another way to indicate his/her needs?

Clinical Notes:

<u>Functional Expression</u>

Describe your child's independence in:

Personal Hygiene –

Dressing –

Toileting –

<u>Sleep</u>

Describe your child's sleeping habits (e.g. does your child sleep through the night, have trouble falling asleep, restless sleep, early to wake, what is the length of your child's sleep, etc.)

Hearing & Vision

Hearing Screened? Yes ____ No ____ Pass/Fail (circle one)

If Fail, please explain:

Vision Screened? Yes ____ No ____ Pass/Fail (circle one)

If Fail, please explain:

Sensory Integration:

Feeding & Nutrition

Does your child feed him/herself using utensils? Yes ____ No _____

Uses fingers: _______ Fed by caregiver: _____

Describe your child's eating habits:

- Tendency to avoid certain foods/textures? Yes ____ No _____
- Limited variety of foods? Yes _____ No _____
- Willing to try new foods? Yes _____ No _____

What foods does he/she prefer?):

Any food allergies or sensitivities? Yes ____ No ____

If yes, please list:

Clinical Notes:

Current Services: (Speech/Occupational/Physical/Hippo/Aquatic Therapy, behavioral therapy, psychotherapy, tutoring, etc., name of provider, number of sessions/length of session per week):

Medical/Surgical History:

A. Does your child have any reactions to medications? (please explain)

B. Does your child have any seasonal and/or other allergies or sensitivities?

C. Are your child's immunizations up to date?

D. Is there a history of any hospitalizations? (Please provide dates and reason for hospitalization.)

E. Have you ever had to bring your child to the emergency room? (Please provide dates and reason for ER visit.)

F. Has your child ever had any surgeries? (Please provide dates and procedures.)

G. Has your child ever had any serious injuries? (Please provide dates and nature of injury.)

H. Other Illnesses: (Please provide dates and nature of illness.)

Review of Systems: (Please list all specialists, contact information, and reason for seeing specialist)

1. **Neurology:** (e.g. Seizures, headache, tics, etc)

2. **Orthopedics:**

3. **Ophthalmology**:

4. **Pulmonary**: (e.g. Asthma or Wheezing)

5. **Gastroenterology:** (e.g. Vomiting & Bowel Movements)

6. **ENT:** (e.g. Ear Infections)

7. **Endocrine:** (e.g. Thyroid)

8. **Urologist:**

9. **Cardiovascular:**

10. **Genetics:**

11. **Other:**

Medications
List Past:

	Medication	Reason & Date for Starting	Reason & Date for Stopping
1.			
2.			
3.			

Present:

	Medication	Reason & Date for Starting	Current Benefit
1.			
2.			
3.			

Previous Evaluations/Testing *(Medical, Psychological Evaluations)*

	Test	Date	Results
1.			
2.			
3.			
4.			

Please attach any previous evaluations your child has received.

We appreciate you taking the time to complete this form for us to review.

Please feel free to provide any additional information below: