DEVELOPMENTAL PEDIATRICS HISTORY FORM

IDENTIFYING INFORMATION:

Child's Name:_____ Date of birth:_____

Date form completed:_____ Referred by:_____

Parents' names: _____

_____

Phone number: (home)_____Cell #_____

Cell #_____Work#_____

REASON FOR REFERRAL:

What are you hoping to learn from this evaluation? (Main questions, concerns, etc.)

_____
_____
_____
_____

What diagnoses does your child have?

Autism_☐_
ADHD_____☐
Sensory integration or sensory processing disorder_☐_
Language delay_☐_
Cerebral palsy_____☐
Other_____

PREGNANCY/BIRTH HISTORY:

Pregnancy: Full-term? _☐_ Premature? _☐_ Weeks gestation? _____

Birth weight _____ Apgar scores _____

Type of delivery: Vaginal _☐_
Cesarean Section _☐_ Why? _____

Complications during pregnancy? (bleeding, high blood pressure, infections, diabetes, etc.)

_____

Amniocentesis? _☐_ Results/concerns: _____

Ultrasounds? _☐_ Results/concerns: _____

Exposure during pregnancy?:
Rhogam_____(shot for Rh negative blood type)
Flu Shot_____
Medications_____
Cigarettes/alcohol/recreational drugs?_____
During pregnancy, was your child unusually active? _____ Under-active?_____
Any problems after delivery? NICU_____ Jaundice _____ phototherapy _____
Respiratory problems_____
Need for oxygen? _____ Ventilator? _____
Infections _____
Poor feeding _____ Apnea _____
ROP_____ IVH_____ Seizures _____
Any problems in early infancy? Unusually quiet _____ Unusually active _____ Colic_____
Unusually stiff or floppy _____ Feeding problems _____
Breast-fed/ formula fed? _____ Type of formula? _____

Feeding problems: _____

MEDICAL HISTORY:
Primary care physician:_____

Last routine physical examination? _____

Were any problems identified? _____

Are your child's immunizations up-to-date? _____ Any adverse reactions? _____

Has your child had: Blood test for lead? _____ Thyroid function? _____
Hearing screening or audiology evaluation? _____
If yes, date and results? _____
Vision screening or ophthalmology evaluation ? _____
If yes, date and results? _____
Are you concerned about your child's hearing or vision? _____
Has your child had any medical evaluation for the cause of his/her behavioral, developmental, or medical symptoms (e.g., head MRI, EEG, blood or urine tests, etc)? Please attach copies for my review:

_____

Any history of: Serious illnesses? _____
Serious injuries? _____
Surgeries? _____
Hospitalizations? _____

Is your child currently on any routine medication? _____

REVIEW OF SYSTEMS:

Please indicate whether your child now has, or has had in the past, any of the following. (Please indicate at what ages these areas were problematic.)

☐ Ear infections_____

☐ Frequent illnesses_____

☐ Frequent need for antibiotics_____

☐ Diarrhea_____

☐ Constipation_____

☐ Gas/Belching/Reflux_____

☐ Stomach ache/abdominal cramps_____

☐ Nausea/Vomiting_____

☐ Headaches_____

☐ Allergies to: _____Environment (e.g., pollen, dust)_____

_____Foods_____

_____Medications_____

☐ Eczema/Dry skin_____

☐ Cracking/ peeling nails_____

☐ Asthma_____

☐ Snoring_____

☐ Red cheeks or red ears (without obvious reason)_____

☐ Sweating at night_____

☐ Intolerance to cold or heat_____

☐ Abnormal weight gain or loss_____

☐ Seizures_____

☐ Tics/Eye twitching or blinking_____

☐ Excessive fatigue_____

☐ Excessive thirst_____

Are any medical specialists involved in your child's care (e.g., allergist, neurologist, etc.)? If yes, please list their names/ specialties/phone numbers. Please attach copies of recent reports

_____

_____

(For this section include details only if you have concerns) **(4)**

DIET HISTORY:

Does your child have a good appetite?_____
Is he/she a picky eater?_____
Unusual food preferences or dislikes? Any food cravings?
_____

Do any foods seem to make your child's behavior better or worse? _____
_____

Have you tried any specific types of diets to see if they affected your child's behavior or development (e.g., milk-free, gluten-free, etc.)? Which ones and what was the response?
_____
_____

Is your child currently taking any vitamins or other nutritional supplements? Please list them.
_____
_____
_____

Does your child eat a lot of: Dairy (Milk, cheese, yogurt, etc.): _____
Wheat products? (Bread, pasta, cereal, cookies, etc.) _____

What types of the following foods does your child eat?

Protein (e.g., meat, eggs, peanut butter)_____

Fruit_____

Vegetables_____

DEVELOPMENTAL HISTORY:

Are you concerned about your child's development? _____
If yes, at what age did you first become concerned? _____
What concerned you initially? _____

What age do you think your child acts like, in terms of development and learning? _____
What are your main concerns about your child's development? _____
_____
_____
_____

What are your child's main developmental strengths? _____

_____
_____
_____

Has your child lost previously attained skills? _____
If yes, at what age did the loss begin? _____
What skills were lost? _____
Was there any event, illness, etc. that appeared to coincide with the loss of skills?_____
_____

Has your child had any previous evaluations of his/her development or learning? _____
_____
If yes, please indicate the type of evaluation, date, and general results. (Please bring any reports of previous evaluations or testing with you to your first appointment for us to keep.)
_____
_____

For children under 3yrs please try and recall the details – for older children indicate those areas that were a concern and as much detail as you can recall.

Language skills:

Please indicate the age at which your child achieved the following skills:

Social smile (smiled in response to you) _____
Laughed _____
Babbled _____
Said "mama", "dada"_____
Understood "no" _____
Pointed to communicate_____
Said first word _____
Waved bye-bye _____
Played "peek-a-boo"or "pat-a-cake" _____
Followed a one-step instruction _____
Pointed to pictures _____
Identified body parts _____
Combined two-words _____
Had a 50-word vocabulary _____
Spoke in short (at least three-word) sentences _____
Used pronouns (e.g., I, me, you) correctly _____
Able to state full name_____
Able to state age _____
Identified basic colors _____

Did your child have an early or unusual interest in letters or numbers?_____

Is your child literal? (Doesn't understand "It's raining cats and dogs" or "I've to a frog in my throat .")_____

Does he/she have difficulty with conversations?_____

Does he/she repeat memorized words/phrases from books, videos?_____

Any problems with articulation (clarity of speech)? _____

Has your child been diagnosed with apraxia or dyspraxia?_____

Does your child use any type of augmentative communication (such as sign language, PCS, or picture symbols, computer device?)_____

If under age 3 (or if you have concerns in this area), estimated vocabulary size? _____

Does your child have trouble understanding what is asked of him/her? _____

Does he/she seem to have difficulty processing information quickly? _____

Does he/she have difficulty expressing himself/herself? _____

Does he/she have difficulty following multi-step directions? _____

Are any languages other than English spoken in the home? _____

Gross motor skills:

Rolled over _____
Sat alone_____
Crawled _____
Walked independently_____
Walked up steps_____
Pedaled tricycle_____
Rode bicycle: With training wheels _____ Without training wheels _____
Skipped _____
Currently coordinated? _____ Clumsy? _____ Average? _____

Fine motor/Adaptive skills:

Right-handed or left-handed? _____
Picked up small objects with a pincer (thumb-forefinger) grasp_____
Scribbled with a crayon _____
Fed self with fingers_____
Used spoon/fork_____
Drank from a cup_____
Toilet-trained _____
Undressed self completely_____

Dressed self completely _____
Unbutton/button_____
Zippers_____
Tied shoes_____
Able to put shoes on correct feet_____
Handwriting: Legible?_____
Trouble with spacing and sizing of letters?_____
Trouble planning on the page(e.g., runs out of room)?_____

BEHAVIORAL HISTORY:

Are you concerned about your child's behavior? _____
If yes, what are your main concerns about your child's behavior?_____
_____
_____

What are your child's behavioral strengths? _____
_____
_____

Has you child ever had any evaluations of his/her behavior? _____
If yes, please indicate type of evaluation, date and general results. (Please bring reports of any previous evaluations to your first appointment for us to keep.)
_____
_____

Has your child ever received any formal interventions regarding his/her behavioral difficulties (such as counseling/therapy, medication, etc.)?
_____
_____

Is your child currently on any medications for behavior?_____

Please indicate whether your child has difficulties in any of the following areas:

Hyperactivity
Inattention
Impulsivity
Distractibility
Significant variability in behavior from day to day

Temper tantrums
Oppositional/defiant behavior
Aggressiveness
Destructiveness

Lying

(8)

Stealing
Self-injurious behaviors
Bed wetting
Soiling/encopresis
Difficulty getting along with siblings or peers
Trouble making friends
Depressed mood
Mood swings
Low self-esteem
Sleep problems
Withdrawn behavior
Anxiety/Nervousness
Nail biting
Thumb sucking
Obsessions
Compulsions
Prefers to play alone
Poor eye contact
Lack of make-believe play
Trouble with transitions
Unusual sensitivities (e.g., to sounds, being touched, tags on clothing)
Hand flapping/finger flicking

EDUCATIONAL HISTORY:

Do you have any concerns about your child's learning or school placement? _____
_____

Current school: _____

Grade: _____ Estimated number of children in classroom _____
Type of classroom (Regular education, special education) _____
Has your child ever repeated a grade? _____

Has your child had any formal testing regarding his/her learning (such as psychological testing, educational testing, speech/language evaluation)? If yes, please bring reports of previous testing or evaluations to the first appointment for us to keep.

_____
_____
_____

Is your child receiving any special services at school or outside of school (such as speech-language therapy, occupational therapy, tutoring, etc.)? If yes, please list type of therapy, where received, and the frequency of therapy.

Speech therapy_____
Occupational therapy_____
ABA/VB_____
Floor Time_____
Other_____

What are your child's best subjects in school?_____

Most difficult subjects?_____

How do you think your child learns best? Visual learner _____
Auditory learner _____
"Hands on" learner _____

FAMILY/SOCIAL HISTORY:

Please indicate whether the following illnesses/disorders are present in your family's history and who has/had them:

Attention Deficit Hyperactivity Disorder ☐
Learning Disability ☐
Mental Retardation ☐
Autism/Pervasive Developmental Disorder ☐
Language Delay ☐
Articulation Problems ☐
Fragile X Syndrome ☐
Hearing Impairment ☐
Vision Impairment ☐
Seizures ☐
High Blood Pressure ☐
Heart Disease (including abnormal heart rhythms, sudden death) ☐
Thyroid Disease ☐
Allergies ☐
Asthma ☐
Gastrointestinal Problems (Inflammatory bowel disease, celiac disease, irritable bowel syndrome, etc.) ☐
Autoimmune disorders (lupus, rheumatoid arthritis) ☐
Tics/Tourette's Syndrome ☐
Depression ☐
Anxiety ☐
Obsessive-Compulsive Disorder ☐
Bipolar Disorder (Manic-Depressive Illness) ☐
Schizophrenia ☐
Other_____

Who currently lives in the household? _____

Are parents: Married? _____ Separated? _____ Divorced? _____

Father's occupation: _____

Mother's occupation:_____

Names and ages of siblings, and any behavioral or developmental concerns:

_____

_____

_____

Any recent social stressors (e.g., deaths/losses, moves, change in family situation

Additional information: