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Dear Parent/Guardian:

Thank you for choosing St. Luke’s Developmental Pediatrics for your child’s care. We have received the referral from your child’s doctor requesting an appointment with our office. For us to schedule an appointment for your child, we will first need the following information:

o The completed intake packet (enclosed)

o A copy of front and back of your insurance card

o School or outside program evaluation, IEP (if applicable)

o Early Intervention evaluation (if applicable)

o Intermediate unit evaluation (if applicable)

o Custody Paperwork (if applicable)

This can be submitted by mail, fax, or e-mail listed above. Incomplete packets will be returned which will lead to delay in the process. Once everything is received, please allow approximately 16 weeks for us to review. We will then contact you to schedule an appointment. *If your child’s needs are best served elsewhere, we will try to direct you towards the appropriate resources*.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Due to the high demand of Developmental Pediatricians, if your child has been evaluated by another Developmental Pediatrician prior to their scheduled appointment with our office, we will**

**be required to cancel your child’s appointment. Thank you for your understanding. \***

**\*At this time we DO NOT participate with the following Insurance Plans:**

* **United Healthcare Community Plan**
* **Aetna Better Health**
* **Populytics**
* **Cigna (unless plan allows for out of network coverage, please contact the Payor for benefit details)**

**\*If your child’s insurance is changed to any of the plans listed above, their appointment may be cancelled unless the appropriate out of network approvals have been processed. *If you have any questions regarding your child’s coverage or if you are self-pay, please contact the office to discuss payment options prior to completing the intake process.*** Please sign that you have read and understand the above information

X:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature of parent or guardian)

*Si usted necesita ayuda completando este paquete, por favor de llamar a nuestra oficina*

Date:\_\_\_\_\_\_\_\_\_\_\_ **\*Please complete this form in full.**

Person Completing Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Childs Age:\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_Gender:\_\_\_\_

Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_ Written Language: \_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter Needed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School District:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you give us permission to leave voicemails at the numbers listed above?  Yes  No \_\_\_\_\_\_\_\_\_\_\_(initials)

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (To access St. Luke’s MyChart)

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**Are there any custody issues or orders of protection of which we should be aware?**  Yes\*  No

**\*If yes, describe (Copy of court orders required):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Legal Guardian(s):  Mother  Father  Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent 1 : Last name\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_ Legal Guardian? :  Yes  No

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check if same as child

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed:  Full-Time  Part-Time  Other Employers Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Level Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian(s):  Mother  Father  Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent 2 : Last name\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_ Legal Guardian? :  Yes  No

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check if same as child

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed:  Full-Time  Part-Time  Other Employers Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Level Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Marital Status :  Married  Divorced  Separated  Never Married  Widowed

Child’s Caregivers:  Biological  Adoptive  Foster  Other

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Doctor’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscribers DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Composition**

Please check those with whom the child lives (Write in names):

 Biological Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Biological Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Step-Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Step-Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Adoptive Mother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Adoptive Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Grandmother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Grandfather:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Guardian(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Siblings** |
| Name (First & Last) | Full, Half, Adoptive or Step (If half, maternal or paternal) | Age | Date of Birth | Medical or Behavioral Issues | Lives in the home |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Does your child attend any of the following?

 Daycare (list days/times child attends):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Before or After-school program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Extracurricular Activities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any notable stressful events that the child or family is currently experiencing or have experienced?

 Yes  No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like us to know about your child or family at this time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Biologic Family Medical and Psychiatric History**

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| **Does anyone in this child’s biologic family have:** | **Yes** | **No** | **Relationship to the child? Please specify maternal or paternal.** |
| ADHD/ADD or Attentional Issues |  |  |  |
| Alcohol Abuse |  |  |  |
| Anxiety |  |  |  |
| Arrhythmia or heart problems before age 50 if yes, **describe** |  |  |  |
| Autism Spectrum Disorder |  |  |  |
| Behavior Problems or Trouble with the law |  |  |  |
| Bipolar Disorder |  |  |  |
| Birth Defects |  |  |  |
| Depression |  |  |  |
| Developmental Delays (late walker/talker) |  |  |  |
| Diabetes |  |  |  |
| Drug Abuse |  |  |  |
| Emotional Abuse |  |  |  |
| Genetic Diagnosis |  |  |  |
| Hearing Loss  |  |  |  |
| Intellectual Disability (formerly mental retardation) |  |  |  |
| Learning Difficulties or disability (reading, writing, math, etc.) |  |  |  |
| Obesity |  |  |  |
| Obsessive-Compulsive Disorder (OCD) |  |  |  |
| Physical Abuse |  |  |  |
| Schizophrenia |  |  |  |
| Seizures/epilepsy  |  |  |  |
| Sexual Abuse |  |  |  |
| Sudden Death before Age 50 |  |  |  |
| Tics/Tourette’s Syndrome |  |  |  |
| Vision Loss (eye glasses) |  |  |  |
| Other Conditions/Diagnoses – specify |  |  |  |

**Reason for Visit**

Who initially referred you to our office for an evaluation?

 Primary Doctor  Psychologist/Counselor  School  Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral (please be as specific as possible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you spoken with your child’s primary doctor about your concerns ?:  Yes  No

When were the concerns about your child first noted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Parental Concerns** |
| What are your top 3 concerns regarding your child? |
| 1. |
| 2. |
| 3. |
| What are your child’s top 3 strengths? |
| 1. |
| 2. |
| 3. |

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| **Treatment Goals** |
| Are you seeking an evaluation/diagnostic services? |  Yes |  No |
| Are you seeking information on counseling/therapy? |  Yes |  No |
| Are you seeking medication, consultation and/or management? |  Yes |  No |
| Are you seeking a second opinion? |  Yes\* |  No |
| \*If yes, we will need a copy of the initial assessment: |
| Is there anything outside of the above that you are hoping to get from your visit with our office?  |

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| **Specific Concerns** |
| Our office provides a variety of services. In order to best assess if we can meet your needs, please help us understand your specific concerns.  |
| **Are you concerned about any of the following?:** | **Yes** | **No** | **Please describe** |
| Anxiety |  |  |  |
| Attention difficulties |  |  |  |
| Behavioral challenges |  |  |  |
| Hyperactivity or impulsivity |  |  |  |
| Learning difficulties |  |  |  |
| Moodiness or irritability |  |  |  |
| School problems |  |  |  |
| Situational stressors |  |  |  |
| Sleep difficulties |  |  |  |
| Social difficulties |  |  |  |
| Tics |  |  |  |
| Toilet training difficulties |  |  |  |
| Other (specify): |  |  |  |

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| **Developmental-Behavioral Diagnoses** |
| **Has your child ever been diagnosed with any of the following? If there are ‘Concerns’, though not diagnosed, please check ‘Concerns’** | **Yes** | **No** | **Concerns, though not diagnosed** | **Date Diagnosed** | **By Whom?** |
| Anxiety Disorder |  |  |  |  |  |
| Attention Deficit/Hyperactivity Disorder |  |  |  |  |  |
| Autism Spectrum Disorder(includes Autistic Disorder/Autism, Asperger syndrome, Pervasive Developmental Disorder – Not otherwise specified) |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Developmental Delay |  |  |  |  |  |
| Intellectual Disability (previously mental retardation) |  |  |  |  |  |
| Language Disorder |  |  |  |  |  |
| Learning Disability |  |  |  |  |  |
| Mood Disorder |  |  |  |  |  |
| Obsessive-Compulsive Disorder (OCD) |  |  |  |  |  |
| Oppositional Defiant Disorder (ODD) |  |  |  |  |  |
| Other (specify): |  |  |  |  |  |

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| **Medication History** |
| Does your child take any supplements or medications for *inattention, anxiety, behavior, mood or sleep?* | Yes\* | No |
| \*Please list **all medications and supplements** your child is currently taking |
| **Name of Medication** | **Reason for taking** | **Dosage** | **Frequency** | **Period taken** | **Prescribed by whom?** |
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| Has your child **previously** taken medications or supplements for these concerns | Yes\* | No |
| \*Please list all **medications and supplements** your child has **previously taken** for inattention, anxiety, behavior, mood, sleep |
| **Name of medication** | **Reason for discontinuation** | **Dosage** | **Frequency** | **Period taken** | **Prescribed by whom?** |
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| **Professional Evaluations** |
| Has your child previously been evaluated by any of the following providers? (Please check all that apply and provide copies of reports) |
|  | Previous Evaluations | Provider Name | Evaluation Date | Diagnosis |
| Developmental Pediatrician (CHOP, LVPG, St Christopher, other) | Yes | No |  |  |  |
| Neurologist | Yes | No |  |  |  |
| Psychiatrist | Yes | No |  |  |  |
| Psychologist | Yes | No |  |  |  |
| Speech Therapist | Yes | No |  |  |  |
| Occupational Therapist | Yes | No |  |  |  |
| Physical Therapist | Yes | No |  |  |  |
| Feeding Therapist | Yes | No |  |  |  |
| Other (GI, Pulm, vision, Audiology, Cardiology, ENT,etc): | Yes | No |  |  |  |
| **Counseling Services** |
| Is your child currently receiving or has your child previously received counseling services – either privately or through the school district? | Yes\* | No |
| \*If yes, indicate name of therapist and dates seen: |

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| **Medical Test**: including, but not limited to EEG, MRI, CT scan, EKG, genetic or metabolic testing, etc.? |
| **Year** | **Type of Testing** | **Where was it done?** | **Results** |
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| **Lead Testing**Date of last lead level:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any history of elevated lead level? Yes No If yes, peak level\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hearing Testing**Passed newborn hearing screen?  Yes  NoHas child passed hearing screens through doctor or school?  Yes NoHas formal hearing testing even been done at speech/hearing center or ENT? Yes NoIf yes, date done:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

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| **Any Hospitalizations or Surgeries?** |
| **Date** | **Reason** | **Location** |
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| --- | --- | --- | --- |
| **Pregnancy, Labor and Delivery History** | **Yes** | **No** | **Comment** |
| Age of mother when child was born \_\_\_\_ years |  |  |  |
| Is this child a twin or triplet? |  |  |  |
| Any problems with other pregnancies? Miscarriages? |  |  |  |
| Use *in vitro fertilization* or other method of conception? |  |  |  |
| Were there any problems during *this* pregnancy? |  |  |  |
| Any medications prescribed? Why?  |  |  |  |
| Gestational diabetes (sugar in urine)? |  |  |  |
| Any problems with blood pressure or toxemia? |  |  |  |
| Any problems with infections (including herpes)? |  |  |  |
| Smoking during pregnancy? (How many packs per day)? |  |  |  |
| Alcohol Consumed (beer, wine, etc.) during pregnancy? |  |  |  |
| Any street drugs (marijuana, cocaine, etc.) used? |  |  |  |
| Any problems during labor or delivery? |  |  |  |
| Cesarean delivery? Why? |  |  |  |
| Baby was born at \_\_\_\_ weeks |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Newborn History** | **Yes** | **No** | **Comments** |
| Birth weight? \_\_\_\_Lbs. \_\_\_\_oz. |  |  |  |
| Were there any problems at birth or as a newborn? |  |  |  |
| Were any birth defects or birth injuries noted? |  |  |  |
| Put in Special care or intensive care nursery? \*If yes how many days? \_\_\_\_ |  |  |  |
| Have Jaundice and need phototherapy? |  |  |  |
| Very jittery or lethargic as a newborn? |  |  |  |
| Baby had to stay extra days in the hospital? \*If yes how many days? \_\_\_\_  |  |  |  |

|  |
| --- |
| **Infant Temperament** |
| Please describe your child as an infant or toddler: |
|  | **Yes** | **No** | **Comment** |
| Problems with feeding in infancy? |  |  |  |
| Severe or prolonged colic or excessive crying? |  |  |  |
| Difficult temperament (irritable or demanding)? |  |  |  |
| Excessively wiggly or active? |  |  |  |
| Easily over-stimulated? |  |  |  |
| Passive, shy or withdrawn? |  |  |  |
| Didn’t like to be held or cuddled? |  |  |  |
| Trouble keeping a babysitter? |  |  |  |

|  |
| --- |
| **Current or Past Medical Symptoms** |
|  | **Yes** | **No** | **Comments** |
| Serious/chronic medical problems? If Yes, describe: |  |  |  |
| Serious illness or infection |  |  |  |
| Serious injury, burns, or broken bones? |  |  |  |
| Known genetic problems? |  |  |  |
| Has growth been normal? |  |  |  |
| Small for age or underweight? |  |  |  |
| Large for age or overweight? |  |  |  |
| Head injury, loss of consciousness, concussion? |  |  |  |
| Staring spells? |  |  |  |
| Seizures or convulsions? |  |  |  |
| Frequent headaches or migraines? |  |  |  |
| Problems with eyes or vision? |  |  |  |
| Problems with hearing? |  |  |  |
| Motor tics (blinking, head tilts, arm movements, etc.)? |  |  |  |
| Vocal tics (sniffing, grunting, throat clearing, etc.)? |  |  |  |
| **Current or Past Medical Symptoms (continued)** |
|  | **Yes** | **No** | **Comments** |
| Tooth issues or cavities? |  |  |  |
| Brushes teeth at least twice a day? |  |  |  |
| Regularly sees dentist for routine care? |  |  |  |
| Frequent ear infections with chronic antibiotics and/or tubes? |  |  |  |
| Respiratory or lung problems (asthma, pneumonia, etc.)? |  |  |  |
| Heart problems or arrhythmias? |  |  |  |
| Dizziness or fainting spells? |  |  |  |
| Gastroesophageal reflux? |  |  |  |
| Unexplained or recurrent episodes of vomiting? |  |  |  |
| Constipation? |  |  |  |
| Diarrhea or other bowel problems? |  |  |  |
| Soils pants or has bowel accidents? |  |  |  |
| Daytime urinary incontinence (‘wets’ pants)? |  |  |  |
| Wets at night? |  |  |  |
| Thyroid or hormone problems? |  |  |  |
| Loose or floppy body? |  |  |  |
| Rigid/stiff body? |  |  |  |
| Leg pains? |  |  |  |
| Birth marks? |  |  |  |
| Skin problems? |  |  |  |
| Are immunizations up-to-date? |  |  |  |
| Unusual reaction to immunizations? |  |  |  |
| Known exposure to toxic chemical’s or poisons? |  |  |  |
| Current or past use of tobacco, alcohol or drugs? |  |  |  |

|  |
| --- |
| **Development History** |
|  | **Approximate Age Accomplished** | **Too Young** |
| Sat without support |  |  |
| Walked |  |  |
| Spoke first words (except mama/dada) |  |  |
| Spoke in two-three word sentences |  |  |
| Toilet trained during the day |  |  |
| Dry at night |  |  |
| Able to dress self |  |  |
| Rode a tricycle |  |  |
| Read simple words  |  |  |
| Able to tie shoes |  |  |
| Has your child ever had a regression in skills (loss of previously acquired skills) outside of those that occur during breaks from school? Yes  No If yes, please explain. |  |  |

|  |
| --- |
| **Current Development Skills** |
|  | **Above Average** | **Average** | **Below Average** | **Doesn’t Apply** |
| Ability to understand spoken words (receptive language) |  |  |  |  |
| Ability to speak clearly (expressive language) |  |  |  |  |
| Conversation skills (turn taking, use of polite language) |  |  |  |  |
| Ability to use fingers to write legibly or draw (fine motor) |  |  |  |  |
| Ability to use large muscles to run or play (gross motor) |  |  |  |  |
| Ability to make friends/play with other children (social skills) |  |  |  |  |
| Ability to dress, feed and/or clean self (adaptive skills) |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **A little** | **No** | **Comments/Example** |
| Does your child struggle with learning colors, shapes, numbers, letters? |  |  |  |  |
| No interest in playing with other children |  |  |  |  |
| Difficulty making friends |  |  |  |  |
| Difficulty picking up on social cues |  |  |  |  |
| Uses repetitive or scripted language |  |  |  |  |
| Echoes language that was heard (echolalia) |  |  |  |  |
| Uses peculiar/odd language |  |  |  |  |
| Difficulty initiating or maintaining conversations  |  |  |  |  |
| Difficulty understanding tone of voice |  |  |  |  |
| Difficulty understanding humor/jokes or sarcasm  |  |  |  |  |
| Difficulty understanding gestures/body language |  |  |  |  |
| Difficulty making or using eye contact |  |  |  |  |
| Literal or concrete in thought |  |  |  |  |
| Does not know how to play with toys |  |  |  |  |
| Play is repetitive (does the same thing over and over) |  |  |  |  |
| Difficulties with imaginative play |  |  |  |  |
| Strong interests in specific toys/topics |  |  |  |  |
| Unusual interest (please explain) |  |  |  |  |
| Repetitive behaviors (hand flapping, toe-walking, etc.) |  |  |  |  |
| Visual fascination with lights |  |  |  |  |
| Sensory difficulty (sights, smells, noises, tastes, touch) |  |  |  |  |
| Unusually tolerance to pain (high or low) |  |  |  |  |
| Bothered by how things feel (clothing, hugs, etc.) |  |  |  |  |

|  |
| --- |
| **Sleep History** |
|  | **Yes** | **No** | **Comments** |
| Does your child have trouble falling asleep? |  |  |  |
| Does your child have trouble staying asleep?  |  |  |  |
| Does your child have frequent nightmares? |  |  |  |
| Does your child have any night terrors or sleep walking? |  |  |  |
| Does your child snore? |  |  |  |
| Does your child wake up early? |  |  |  |
| Does your child have difficulty waking in the morning? |  |  |  |
| Does your child have daytime fatigue or nap? |  |  |  |
| Is anyone present when your child falls asleep? |  |  |  |
| Describe where your child sleeps? (ex: crib, bed, shares a room, in parents room) |  |

|  |
| --- |
| **Nutrition/Diet** |
|  | **Yes** | **No** | **Comments** |
| Any history of or current feeding/eating difficulties? |  |  |  |
| Is the child a picky eater? |  |  |  |
| Does the child eat from all food groups (meat/protein, dairy, complex carbohydrates, fruits, vegetables)? |  |  |  |
| Any special dietary modifications? If yes, specify. |  |  |  |
| Takes any vitamins or supplements? If yes, specify. |  |  |  |
| **Below please list some of the foods from each food group that the child regularly eats:** |
| Meats/proteins: |
| Dairy or dairy alternative: |
| Complex Carbohydrates(bread, pasta, rice, cereal, snacks):  |
| Fruits: |
| Vegetables: |
| **Nutrition/Diet (continued)** |
| What is the child’s main source of iron?(common sources include red meats, leafy green vegetables, beans/legumes, nuts, vitamins with iron) |  |
| What is the child’s main source of calcium/vitamin D? (common sources include dairy products, or dairy alternatives, supplements/vitamins) |  |
| **How many cups are consumed daily of the following liquids?** | **# Cups/day** | **Comments** |
| Milk |  |  |
| Water |  |  |
| Juice |  |  |
| Soda/sugar-sweetened drinks |  |  |

|  |
| --- |
| **Screen Time** |
|  | Yes | No | Comments |
| Does your child watch TV/movies?If yes, how many hours per day? \_\_\_\_\_ |  |  |  |
| Does your child use electronic devices with screens (e.g. video games, tablets, smartphones, computers, etc.)?If yes, how many hours per day? \_\_\_\_\_ |  |  |  |
| Is there a TV in your child’s bedroom? |  |  |  |
| Does your child watch TV or use other devices with screens in the 2 hours before bedtime? |  |  |  |
| **Safety** |
|  | **Yes** | **No** | **Please explain** |
| Does child place non-food items in mouth? |  |  |  |
| Does child wander/elope? |  |  |  |
| Is the home child-proofed? |  |  |  |
| Does anyone smoke or use e-cigarettes in the home (including basement) or car? |  |  |  |
| Are there any guns in the home? |  |  |  |
| *Are the guns stored in a locked place?* |  |  |  |
| *Are bullets stored separately from guns?* |  |  |  |
| Is the child exposed to yelling or physical violence in the home? |  |  |  |
| Has the child ever experienced abuse (emotional, physical, and/or sexual)? |  |  |  |

|  |
| --- |
| **Tantrums** |
|  | **Yes** | **No** | **Comments** |
| Does your child have frequent tantrums (e.g., emotional outburst that range from yelling to aggression) |  |  |  |
| How many tantrums per day? \_\_\_\_\_ Per week? \_\_\_\_\_ |
| How long do tantrums last on average? \_\_\_\_\_mins How long do tantrums last at their worst? \_\_\_\_\_mins |
| Triggers? |
| What helps your child to calm? |

|  |
| --- |
| **Behavior Management In The Home** (Please check all that apply) |
|  | **Yes** | **No** | **Effective?** | **Comments** |
| Time-out |  |  |  |  |
| Ignoring |  |  |  |  |
| Redirection |  |  |  |  |
| Earning privileges |  |  |  |  |
| Taking away privileges |  |  |  |  |
| Giving more chores |  |  |  |  |
| Yelling |  |  |  |  |
| Spanking |  |  |  |  |
| Other (describe): |  |  |  |  |

|  |
| --- |
| **Behavioral Symptoms** |
|  | **Yes** | **A little** | **No** | **Comments** |
| Strong-willed personality |  |  |  |  |
| Persistent  |  |  |  |  |
| Demanding |  |  |  |  |
| Impatient |  |  |  |  |
| Overly sensitive |  |  |  |  |
| Shuts down when upset |  |  |  |  |
| Friendly with everyone |  |  |  |  |
| Shy or slower-to-warm-up around new people |  |  |  |  |
| Routine oriented or does not like change |  |  |  |  |
| Tends to be more negative in thought |  |  |  |  |
| Tends to be more emotionally reactive or intense |  |  |  |  |
|  |
| Does not respond when name is called |  |  |  |  |
| Daydreams |  |  |  |  |
| Hurries through tasks |  |  |  |  |
| Loses things |  |  |  |  |
| Limited safety awareness |  |  |  |  |
|  |
| Worries often about many things |  |  |  |  |
| Seems restless or on edge |  |  |  |  |
| Frequent muscle or body aches |  |  |  |  |
| Frequent headaches or bellyaches |  |  |  |  |
| Has many fears |  |  |  |  |
| Has difficulty separating from caregivers  |  |  |  |  |
| Has low self-esteem |  |  |  |  |
| Moody/mood swings or rapid mood changes |  |  |  |  |
| Irritable |  |  |  |  |
| Feels sad or appears tearful |  |  |  |  |
| Has lost interest in things he/she once enjoyed |  |  |  |  |
| Changes in appetite (either increase or decrease) |  |  |  |  |
| Unintentional change in weight (loss or gain) or failure to gain expected amount of weight |  |  |  |  |
| Change in sleep (sleeping more or less than usual) |  |  |  |  |
| Seems restless/agitated or moves more than usual |  |  |  |  |
| Self injury (bite, head bang, slap, scratch, etc) |  |  |  |  |
| Unusually happy/elated without obvious reason |  |  |  |  |
| Has unrealistic ideas that are too big/grandiose  |  |  |  |  |
| Rapid or pressured speech (talks too fast) |  |  |  |  |
| Seems over confident in self |  |  |  |  |
| Decreased need for sleep |  |  |  |  |
| Hears voices others do not hear |  |  |  |  |
| Sees things others do not see |  |  |  |  |
| Complains of itching or bug crawling sensation  |  |  |  |  |
| Has imaginary friends  |  |  |  |  |
| **Behavior Symptoms continued** |
| Preoccupation with cleanliness/being contaminated  |  |  |  |  |
| Repetitive actions (counting, repeating actions, praying, etc. ) |  |  |  |  |
| Often things he/she caused something bad to occur |  |  |  |  |
| Repetitive hand washing |  |  |  |  |
| Repetitive checking e.g. making sure door is locked  |  |  |  |  |
| Repetitive lining up/ordering/organizing objects |  |  |  |  |
| Perfectionist  |  |  |  |  |
| Worries often about doing the right thing |  |  |  |  |
| Picking habits – skin, scabs, fingernails, etc.  |  |  |  |  |
| Frequently collects or hoards items |  |  |  |  |
| Unable to throw out items, even if not of value |  |  |  |  |
| Unusual habits (please explain  |  |  |  |  |
| Fearful of gaining weight  |  |  |  |  |
| Overeats or binges on food |  |  |  |  |
| Intentionally vomits food after eating |  |  |  |  |
| Hoard and/or hides food |  |  |  |  |

**Home Situations Questionnaire**

St. Luke’s Developmental Pediatrics

5425 Lanark Road | Center Valley, PA 18034

Phone: 484-658-5437 | Fax: 833-214-7525

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

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Completing Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions**: Does your child present any problems with compliance to instruction, comments or rules for you in any of these situations? If so, please circle the word YES and then circle a number beside that situation that describes how severe the problem is for you. If your child is not a problem in a situation, circle NO and go to the next situation on the form.

|  |  |  |
| --- | --- | --- |
| **Situation** | **Problem Present?** | **How Severe?** |
| **Mild Moderate Severe** |
| Playing Alone | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Playing with other children | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Meal times | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Getting dressed/undressed | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Washing and bathing | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| When you are on the telephone | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| When visitors are in your home | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| When you are visiting someone’s home | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| In public places | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| When father is home (check if not applicable) | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| When asked to do chores | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| When asked to do homework | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| At bedtime | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| When with a babysitter | No | Yes | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

**Please return this form to the address or fax number above.**

**ADHD Rating Scale IV – Preschool / Daycare Version (Parent)**

Childs Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_

Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Circle the number that **best describes** the child’s behavior over the past 6 months | Rarely or never | Sometimes | Often | Very Often |
| 1. Fails to give close attention to details (i.e. rushes through activities, makes careless mistakes)
 | 0 | 1 | 2 | 3 |
| 1. Fidgets with hands or feet or squirms in seat (taps hands or feet)
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty sustaining attention in tasks or play activities
 | 0 | 1 | 2 | 3 |
| 1. Leaves seat in classroom, during meals, or in other situations in which remaining seated is expected
 | 0 | 1 | 2 | 3 |
| 1. Does not seem to listen when spoken to directly (tunes you out)
 | 0 | 1 | 2 | 3 |
| 1. Runs about or climbs excessively in situations in which it is inappropriate
 | 0 | 1 | 2 | 3 |
| 1. Does not follow through on instructions or fails to finish tasks (i.e “go upstairs, get your shoes and socks”; has difficulty with transitions)
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty playing quietly (alone or in groups)
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty organizing tasks and activities (i.e. choosing an activity, getting materials, doing steps in order)
 | 0 | 1 | 2 | 3 |
| 1. Is “on the go” or acts as if “driven by a motor”
 | 0 | 1 | 2 | 3 |
| 1. Avoids tasks that require sustained mental effort (i.e. puzzles, learning ABC’s, writing name)
 | 0 | 1 | 2 | 3 |
| 1. Talks excessively
 | 0 | 1 | 2 | 3 |
| 1. Loses things necessary for tasks or activities (i.e. mittens, shoes, backpack)
 | 0 | 1 | 2 | 3 |
| 1. Blurts out answers before questions have been completed
 | 0 | 1 | 2 | 3 |
| 1. Is easily distracted
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty awaiting turn
 | 0 | 1 | 2 | 3 |
| 1. Is forgetful in daily activities (i.e. forgets papers, forgets directions)
 | 0 | 1 | 2 | 3 |
| 1. Interrupts or intrudes on others
 | 0 | 1 | 2 | 3 |

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|  |
| --- |
| **Daycare Information**  |
| Does your child attend daycare?  Yes  No |
| If yes, please provide the name of the daycare and dates attended: |

|  |
| --- |
| **Preschool Information** |
| Does your child attend preschool? Yes  NoIf yes, please provide all school names and dates attended: |
| Current School: |  |
| School Address: |  |
| Contact numbers: | Phone: | Fax: |
| Preschool or Pre-K: |  |
| Teacher Name(s): |  |
| How is your child doing in school? |  |
| Has your child ever been expelled or suspended? Yes  NoIf yes, please describe the circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Has your child been evaluated by the following?:** | **Age at Evaluation** |
| Early intervention | Yes | No |  |
| Intermediate Unit  | Yes | No |  |
| **Does your child have an IEP?**  Yes  No (If yes, please provide a copy) |
| **Does your child currently receive any support services in school? Please check all that apply** |
|  | 1:1 Aide |  | Special Instruction |
|  | Interpreter |  | Speech Therapy |
|  | Occupational Therapy |  | BHRS (BSC/TSS) |
|  | Physical Therapy |  | Other (specify): |

|  |
| --- |
| **ATTESTATION** |
| Are all of the child’s legal guardians aware this evaluation is being pursued with the opportunity to participate in the process?  Yes  No If no, please explain: |
| I certify that the information throughout this form is to the best of my knowledge and belief, true, correct, and complete. I understand that it is my responsibility to keep up-to-date contact information with this office. I hereby authorize medical evaluation & treatment, as well as release of information for insurance/medical purposes concerning the condition and treatment. I authorize payment from my insurance company to the St. Luke’s University Health Network for services rendered. I agree to pay all fees that incur from any visits or test/procedures to this office that my insurance does not cover. I understand that missed appointments or appointments cancelled without 24 hours notice will be considered a No Show and after 3 No Shows my child may be dismissed by the practice. I understand that evaluations at Developmental Pediatrics are complex and can be lengthy in duration. I understand that in order for the provider to complete a thorough evaluation visitors should be limited to the child being evaluated, the parents or legal guardians of the child, and any healthcare providers that are necessary for caring for the child only (i.e. home health aide or nurse). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature DateChild’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

St. Luke’s Developmental Pediatrics

5425 Lanark Road Suite 200

Center Valley, PA 18034

Phone: 484-658-5437

Fax: 833-214-7525

DATE:

RE:

DOB:

Dear Teacher(s),

The parent(s)/guardian(s) of the above-named child have requested an evaluation with our office. Your input is a very important part of establishing a correct diagnosis. Please have the appropriate teachers complete the attached for and return them to the address or fax number listed above.

Thank you for your cooperation.

St. Luke’s Developmental Pediatrics

5425 Lanark Road Suite 200

Center Valley, PA 18034

Phone: 484-658-5437

Fax: 833-214-7525

**DAYCARE/PRESCHOOL QUESTIONNAIRE**

|  |  |
| --- | --- |
| Name of Student: | Todays Date: |
| Date of Birth: | Age: |
| Program Name: | School District: |
| Program Address: |
| Form Completed By: | Position: |
| With help from: | Position: |
| Contact Person: | Phone Number:  |

|  |
| --- |
| **Please list this child’s strengths as you see them:** |
| 1. |
| 2. |
| 3. |
| 4. |
| **Please list your major concerns for this child:** |
| 1. |
| 2. |
| 3. |
| 4. |
| **What Modifications, strategies, or approaches have been tried? What were the results?** |
|  |
|  |
|  |
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|  |
| **Please attach the following:** |
| Reports of individual or group testing that have been performed on this student (e.g. psychological, academic, standardized state tests, speech/language, OT/PT, social, behavioral assessments, etc.) |
|  If possible, please attach one or more typical samples of this child’s work |
| **If applicable, copies of the student’s**  IEP Behavioral Intervention Plan |

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please describe the student’s current educational program: |
| Program | Frequency | Period of time the child has received services | Direct Service or Consultation? |
|  | Regular Education Class  |  |  | Not Applicable |
|  | Blended/Integrated Class |  |  |
|  | Specialized Class (specify): |  |  |
|  | Number of children in the class |  |
|  | Support Services |
|  |  | 1:1 aide |  |  |  |
|  |  | Consultant Teacher |  |  |  |
|  |  | Counseling |  |  |  |
|  |  | Occupational Therapy |  |  |  |
|  |  | Physical Therapy |  |  |  |
|  |  | Speech/Language Therapy |  |  |  |
|  |  | Other (Specify):  |  |  |  |
|  | Individual Education Plan (IEP |  |  | Not Applicable |
|  | Behavior Intervention Plan |  |  |

**Behavioral Observations**

|  |
| --- |
| **Please check behaviors that you have observed in this student:** |
|  | Difficulty waiting  |  | Strong-willed/persistent  |
|  | Disorganized/loses belongings |  | Shuts down |
|  | Fails to finish tasks |  | Temper tantrum  |
|  | Fidgety/restless |  | Wets or soils pants |
|  | Forgets what she/he just heard |  | Anxious |
|  | Inattentive/easily distracted  |  | Irritable |
|  | Impulsive/doesn’t think before acting |  | Low self-esteem/self-confidence |
|  | Inconsistent performance |  | Often seems fatigued/tired |
|  | Loses interest easily |  | Overly sensitive to touch, noise, light |
|  | Aggressive |  | Slow-to-warm-up/shy |
|  | Defiant |  | Sad/Depressed |
|  | Discipline not effective |  | Over-focuses on specific activities |
|  | Disruptive |  | Repetitive behaviors/movement/play |
|  | Easily angered or frustrated  |  | Socially isolated |

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Please rate your observations of the child’s performance in the following areas:** |
|  | **Developmental functions** | **Deficient for age** | **Appropriate for age** | **Advanced for Age** |
| **Gross Motor** | Large muscle strength |  |  |  |
| Overall coordination  |  |  |  |
| Running speed & agility  |  |  |  |
| Catching/throwing a large ball |  |  |  |
| Jumping, hopping, skipping |  |  |  |
| Learning new motor skills |  |  |  |
|  |
| **Fine Motor** | Holding scissors |  |  |  |
| Holding pencil or crayon |  |  |  |
| Tracing & coloring |  |  |  |
| Managing zippers & buttons |  |  |  |
| Manipulating eating utensils |  |  |  |
| Learning new craft skills |  |  |  |
|  |
| **Visual Spatial** | Distinguishing different sizes & Shapes |  |  |  |
| Copying letters or figures |  |  |  |
| Drawing simple shapes |  |  |  |
| Drawing similar letters (b-d, etc.) |  |  |  |
| Assembling puzzles |  |  |  |
| Learning to write new letters, numbers or shapes |  |  |  |
| Learning where to find things |  |  |  |
|  |
| **Expressive Language**  | Pronouncing words easily |  |  |  |
| Enunciating (articulating) words easily |  |  |  |
| Speaking understandably |  |  |  |
| Speaking full sentences |  |  |  |
| Using words in the right order |  |  |  |
| Size of spoken vocabulary |  |  |  |
| Verbal participation (willingness to speak) |  |  |  |
|  |
| **Receptive Language & memory**  | Following spoken instructions |  |  |  |
| Remembering words to rhymes and songs |  |  |  |
| Showing an interest in stories |  |  |  |
| Understanding of stories |  |  |  |
| Remembering names of letters, numbers objects |  |  |  |
| Understanding instruction without repetition  |  |  |  |
| Learning new words |  |  |  |

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Please rate your observations of the child’s performance in the following areas (continued):** |
|  | **Developmental functions** | **Deficient for age** | **Appropriate for age** | **Advanced for Age** |
| **Time & Sequencing**  | Understanding time concepts |  |  |  |
| Understanding number concepts |  |  |  |
| Doing things in the right order |  |  |  |
| Using time word correctly (before, after, now, later) |  |  |  |
| Following multi-step directions |  |  |  |
| Remember routines, & schedules |  |  |  |
| Adjusting to new routines & schedules  |  |  |  |
|  |
| **Social & Play Skills** | Making eye contact |  |  |  |
| Use of nonverbal communication  |  |  |  |
| Seeking out others for interaction  |  |  |  |
| Ability to play/share with other children |  |  |  |
| Ability to play appropriately with toys |  |  |  |
| Imaginative play skills |  |  |  |
| **Comments & Observations:** |
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**Please return this form to the address or fax number on the first page at your earliest convenience.**

Thank you for your time and effort on behalf of this child.

**ADHD Rating Scale IV – Preschool / Daycare Version (Teacher)**

Childs Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_

Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Circle the number that **best describes** the child’s behavior over the past 6 months | Rarely or never | Sometimes | Often | Very Often |
| 1. Fails to give close attention to details (i.e. rushes through activities, makes careless mistakes)
 | 0 | 1 | 2 | 3 |
| 1. Fidgets with hands or feet or squirms in seat (taps hands or feet)
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty sustaining attention in tasks or play activities
 | 0 | 1 | 2 | 3 |
| 1. Leaves seat in classroom, during meals, or in other situations in which remaining seated is expected
 | 0 | 1 | 2 | 3 |
| 1. Does not seem to listen when spoken to directly (tunes you out)
 | 0 | 1 | 2 | 3 |
| 1. Runs about or climbs excessively in situations in which it is inappropriate
 | 0 | 1 | 2 | 3 |
| 1. Does not follow through on instructions or fails to finish tasks (i.e “go upstairs, get your shoes and socks”; has difficulty with transitions)
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty playing quietly (alone or in groups)
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty organizing tasks and activities (i.e. choosing an activity, getting materials, doing steps in order)
 | 0 | 1 | 2 | 3 |
| 1. Is “on the go” or acts as if “driven by a motor”
 | 0 | 1 | 2 | 3 |
| 1. Avoids tasks that require sustained mental effort (i.e. puzzles, learning ABC’s, writing name)
 | 0 | 1 | 2 | 3 |
| 1. Talks excessively
 | 0 | 1 | 2 | 3 |
| 1. Loses things necessary for tasks or activities (i.e. mittens, shoes, backpack)
 | 0 | 1 | 2 | 3 |
| 1. Blurts out answers before questions have been completed
 | 0 | 1 | 2 | 3 |
| 1. Is easily distracted
 | 0 | 1 | 2 | 3 |
| 1. Has difficulty awaiting turn
 | 0 | 1 | 2 | 3 |
| 1. Is forgetful in daily activities (i.e. forgets papers, forgets directions)
 | 0 | 1 | 2 | 3 |
| 1. Interrupts or intrudes on others
 | 0 | 1 | 2 | 3 |

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