

 5425 Lanark Road Suite 200

 Center Valley, PA 18034

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

Email: Devpeds@sluhn.org

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 need the following information:

* The completed intake packet (enclosed)
* Completed teacher’s questionnaire (enclosed)
* Copy of school district evaluation (if applicable)
* Copy of your child’s IEP or 504 Plan (if applicable)
* Intermediate unit evaluation (if applicable)
* Custody Paperwork (if applicable)
* Copy of any previous evaluations (ie developmental, psychiatrist/psychologist, neurologist, behavioral, etc)
* Copy of your insurance card (front and back)

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. *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**
* **Health Partners**
* **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:\_\_\_\_\_\_\_\_\_\_\_

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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)

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

**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):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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 #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please complete this form in full.**

**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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **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?

School your child attends or type of schooling:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 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**

|  |  |  |  |
| --- | --- | --- | --- |
| **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |
| --- |
| **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. |

|  |
| --- |
| **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?  |

|  |
| --- |
| **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): |  |  |  |

|  |
| --- |
| **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): |  |  |  |  |  |

|  |
| --- |
| **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?** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| 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?** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **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 |  |  |  |
| Behavior Therapist (KidsPeace, Pine Brook, Progressions, PA Mentor, Access, etc.)  | Yes | No |  |  |  |
| Other (Gastroenterology, Pulmonology, Vision, ENT, Audiology, Cardiology, Endocrine Orthopedics, Orthotics 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: |

|  |
| --- |
| **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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **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:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

|  |
| --- |
| **Any Hospitalizations or Surgeries?** |
| **Date** | **Reason** | **Location** |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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) |  |  |  |  |

|  |
| --- |
| **Learning and Behavioral Symptoms** |
|  | **Yes** | **A little** | **No** | **Comments** |
| Difficulty learning shapes or colors |  |  |  |  |
| Difficulty learning numbers or counting  |  |  |  |  |
| Difficulty learning the alphabet/letters |  |  |  |  |
| Difficulty sounding out or reading words |  |  |  |  |
| Difficulty with reading comprehension  |  |  |  |  |
| Difficulty writing (not due to fine motor issues) |  |  |  |  |
| Difficulty with math calculations |  |  |  |  |
| Difficulty with math word problems |  |  |  |  |
| Unable to complete school work independently  |  |  |  |  |
| Unable to complete homework independently |  |  |  |  |
| Takes an extended amount of time for homework  |  |  |  |  |
| Does not seem to retain learned information  |  |  |  |  |
| Memory difficulties  |  |  |  |  |
| Difficulty with multi-step problem solving  |  |  |  |  |
| Believes he/she is not as smart as other peers |  |  |  |  |
| Clumsy/not coordinated |  |  |  |  |
| Poor hygiene |  |  |  |  |
| Often complains of not feeling well before school |  |  |  |  |
| Often objects or refused to go to school |  |  |  |  |
| Frequent school absences  |  |  |  |  |
| 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 |  |  |  |  |

|  |
| --- |
| **Learning and Behavioral Continued** |
|  | **Yes** | **A little** | **No** | **Comments** |
| 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.) |  |  |  |  |
| Moves more slowly than usual |  |  |  |  |
| Seems tired or easily fatigued  |  |  |  |  |
| Makes negative comments about self  |  |  |  |  |
| Unable to concentrate or think clearly |  |  |  |  |
| Has talked about hurting or killing self |  |  |  |  |
| Has shared a plan about hurting or killing self |  |  |  |  |
| Has attempted to hurt or kill self  |  |  |  |  |
| Body rocks |  |  |  |  |
| Head banging |  |  |  |  |
| Cries often or easily |  |  |  |  |
| Difficulty being consoled or self-soothing  |  |  |  |  |

|  |
| --- |
| **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. |  |  |  |
| **Nutrition/Diet (Continued)** |
| **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: |
| 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 |  |  |  |  |
| Fidgety |  |  |  |  |
| Poor educational/planning skills |  |  |  |  |
| Loses things |  |  |  |  |
| Limited safety awareness |  |  |  |  |
|  |
| Worries often about many things |  |  |  |  |
| Seems restless or on edge |  |  |  |  |
| Frequent muscle or body aches |  |  |  |  |
| **Behavioral Symptoms (continued)** |
| 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 to have racing thoughts |  |  |  |  |
| 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  |  |  |  |  |
| Preoccupation with cleanliness/being contaminated  |  |  |  |  |
| Repetitive actions (counting, repeating actions, praying, etc. ) |  |  |  |  |
| Often thinks 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 |  |  |  |  |

|  |
| --- |
| **School Information** |
| Before or after school daycare? Yes  NoIf yes, please provide all preschool and school names and dates attended: |
| Current School: |  |
| School Address: |  |
| Contact numbers: | Phone: | Fax: |
| Grade: |  |
| 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 |  |
| School District | Yes | No |  |
| **Does your child have any of the following plans in school:** | **Yes \*If yes, please provide copies of the IEP, 504 and Reevaluation\*** | **No** |
| 504 Plan | IEP (Individual Education Plan) | Behavior Intervention Plan |
| **Does your child currently receive any support services in school? Please check all that apply** |
|  | 1:1 Aide or paraprofessional  |  | Special Instruction |
|  | Interpreter  |  | Speech Therapy |
|  | Occupational Therapy |  | Physical Therapy |
|  | Behavioral supports: wrap around services, provider 50, BHRS , IBHS (BSC, TSS, RBT, MT) |  | Other (specify): |
|  | Teacher of the Deaf (TOF) |  | Teacher of the visually impaired (TOVI)Teacher of the Deaf  |
| Did your child attend preschool? Yes  NoIf yes, please provide school name and dates attended: |

**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.**

**Parent Behavior Rating Scale Initial**

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Each rating should be considered in the context of what is appropriate for the age of this child. If the child is on medication, indicate behavior OFF medication with a circle (O) and ON medication with a square (), if known.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Behavior** | **Never** | **Occasionally** | **Often** | **Very Often** |
| Does not pay attention to details or makes careless mistakes | 0 | 1 | 2 | 3 |
| Has difficulty keeping attention to what needs to be done | 0 | 1 | 2 | 3 |
| Does not seem to listen when spoken to directly | 0 | 1 | 2 | 3 |
| Does not follow through when given directions and fails to finish *(not due to refusal or misunderstanding)* | 0 | 1 | 2 | 3 |
| Has difficulty organizing tasks and activities  | 0 | 1 | 2 | 3 |
| Avoids, dislikes, or does not want to start tasks requiring ongoing mental effort | 0 | 1 | 2 | 3 |
| Loses things necessary for tasks or activities *(assignments, pencils books)* | 0 | 1 | 2 | 3 |
| Is easily distracted by noises or other stimuli | 0 | 1 | 2 | 3 |
| Is forgetful in daily tasks  | 0 | 1 | 2 | 3 |
|  |
| Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| Leaves seat when remaining seated is expected | 0 | 1 | 2 | 3 |
| Runs about or climbs too much when not appropriate  | 0 | 1 | 2 | 3 |
| Has difficulty playing or beginning quite play activities | 0 | 1 | 2 | 3 |
| Is “on the go”or often acts as if “driven by a motor” | 0 | 1 | 2 | 3 |
| Talks constantly  | 0 | 1 | 2 | 3 |
| Blurts out answers before questions have been completed | 0 | 1 | 2 | 3 |
| Has difficulty waiting his/her turn | 0 | 1 | 2 | 3 |
| Interrupts or intrudes on others’ conversations and/or activities  | 0 | 1 | 2 | 3 |
|  |
| Argues with adults | 0 | 1 | 2 | 3 |
| Easily loses temper | 0 | 1 | 2 | 3 |
| Actively defies or refuses to go along with adults’ request or rules | 0 | 1 | 2 | 3 |
| Deliberately annoys people | 0 | 1 | 2 | 3 |
| Blames others for his/her mistakes or behaviors | 0 | 1 | 2 | 3 |
| Is touchy or easily annoyed by others  | 0 | 1 | 2 | 3 |
| Is angry or resentful  | 0 | 1 | 2 | 3 |
| Is spiteful and wants to get even  | 0 | 1 | 2 | 3 |
|  |
| Bullies, threatens, or intimidates others  | 0 | 1 | 2 | 3 |
| Starts physical fights | 0 | 1 | 2 | 3 |
| Lies to get our of trouble or to avoid obligations (i.e. “cons” others) | 0 | 1 | 2 | 3 |
| Is truant from school (skips school) without permission  | 0 | 1 | 2 | 3 |
| Is physically cruel to people  | 0 | 1 | 2 | 3 |
| Parent Behavior Rating Scale Initial (continued) |
| **Behavior** | **Never** | **Occasionally** | **Often** | **Very Often** |
| Has stolen things that have value | 0 | 1 | 2 | 3 |
| Deliberately destroys others’ property  | 0 | 1 | 2 | 3 |
| Does not follow through when given directions and fails to finish | 0 | 1 | 2 | 3 |
| Is physically cruel to animals | 0 | 1 | 2 | 3 |
| Has deliberately set fires to cause damage | 0 | 1 | 2 | 3 |
| Has broken into someone else’s’ home, business, or car | 0 | 1 | 2 | 3 |
| Has stayed out late at night without permission  | 0 | 1 | 2 | 3 |
| Has run away from home overnight | 0 | 1 | 2 | 3 |
| Has forced someone into sexual activity  | 0 | 1 | 2 | 3 |
|  |
| Is fearful, anxious, or worried | 0 | 1 | 2 | 3 |
| Is self-conscious or easily embarrassed | 0 | 1 | 2 | 3 |
| Is afraid to try new things for fear of making mistakes | 0 | 1 | 2 | 3 |
| Feels worthless or inferior  | 0 | 1 | 2 | 3 |
| Blames self for problems, feels guilt | 0 | 1 | 2 | 3 |
| Feels lonely, unwanted, or unloved; complains that “no one loves them” | 0 | 1 | 2 | 3 |
| Is sad, unhappy, or depressed | 0 | 1 | 2 | 3 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Performance** | **Problematic** | **Somewhat Problematic** | **Average** | **Above Average** | **Excellent** |
| Overall School Performance  | 1 | 2 | 3 | 4 | 5 |
| 1. Reading
 | 1 | 2 | 3 | 4 | 5 |
| 1. Writing
 | 1 | 2 | 3 | 4 | 5 |
| 1. Math
 | 1 | 2 | 3 | 4 | 5 |
| Overall Home Behavior | 1 | 2 | 3 | 4 | 5 |
| 1. Relationship with parents
 | 1 | 2 | 3 | 4 | 5 |
| 1. Relationship with siblings
 | 1 | 2 | 3 | 4 | 5 |
| 1. Relationship with peers
 | 1 | 2 | 3 | 4 | 5 |
| 1. Participation in organized activities (e.g. games)
 | 1 | 2 | 3 | 4 | 5 |
| 1. Homework completion
 | 1 | 2 | 3 | 4 | 5 |
| 1. Organizational skills
 | 1 | 2 | 3 | 4 | 5 |

|  |
| --- |
| Comments: |

**Please return this form to the address or fax number on the first page.**

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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

|  |
| --- |
| **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, 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 also 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 DateChilds Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

St. Luke’s Developmental Pediatrics

5425 Lanark Road

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

Center Valley, PA 18034

Phone: 484-658-5437

Fax: 833-214-7525

**SCHOOL QUESTIONNAIRE**

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

|  |
| --- |
| **Please list this student’s strengths, both academic and non-academic:** |
| 1. |
| 2. |
| 3. |
| 4. |
| **Please list your major concerns for this student, including academic, behavioral and/or social:** |
| 1. |
| 2. |
| 3. |
| 4. |
| **What Modifications, strategies, or approaches have been tried? What were the results?** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| **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.) |
| Recent Report Card |
| **If applicable, copies of the student’s**  IEP 504 plan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 |  |  |
|  | Co-taught Class |  |  |
|  | Specialized Class (specify)15:1:1 12:1:1 8:1:1 6:1:1 |  |  |
|  | Support Services |
|  |  | 1:1 aide |  |  |  |
|  |  | AIS (Specify): |  |  |  |
|  |  | Consultant Teacher |  |  |  |
|  |  | Counseling |  |  |  |
|  |  | Occupational Therapy |  |  |  |
|  |  | Physical Therapy |  |  |  |
|  |  | Resource Room |  |  |  |
|  |  | Response to Intervention (RtI) |  |  |  |
|  |  | Speech/Language Therapy |  |  |  |
|  |  | Other (Specify):  |  |  |  |
|  | Individual Education Plan (IEPClassification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Not Applicable |
|  | Behavior Intervention Plan |  |  |

|  |
| --- |
| **Please describe the student’s classroom performance in the following areas:** |
| \*Please note the grade level at which the student performs; a report card may be included in addition to this information, though should not be sent in lieu of this information |
| Subject | Grade Level\* | Comments (including approach/materials being used) |
| Reading |  |  |
| Spelling |  |  |
| Handwriting |  |  |
| Written Expression |  |  |
| Math |  |  |
| Social Studies |  |  |
| Science |  |  |

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

**Communication Skills**

|  |
| --- |
| **Please discuss your observations for this student in the following areas:** |
| Language comprehension  |  |
| Verbal Expression |  |
| Participation in discussion |  |
| Ability to “read” social situations |  |
| Conversational Skills |  |

**Behavioral Observations**

|  |
| --- |
| **Please check behaviors that you have observed in this student:** |
|  | Disorganized |  | Easily frustrated |
|  | Fails to finish tasks |  | Anxious |
|  | Fidgety/restless |  | Irritable |
|  | Inattentive/easily distracted  |  | Low self-esteem/self-confidence |
|  | Impulsive |  | Often seems fatigued |
|  | Inconsistent performance |  | Sad/depressed |
|  | Task avoidance  |  | Somatic complaints (headaches/bellyaches, trips to nurse) |
|  | Aggressive |  | Peer difficulties |
|  | Defiant |  | Difficulty making friends |
|  | Disruptive |  | Self-absorbed/in own world |
|  | Easily angered  |  | Socially isolated  |

|  |
| --- |
| **Comments & Observations:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

**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.

**Teacher Behavior Rating Scaled Initial**

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Each rating should be considered in the context of what is appropriate for the age of this child. If the child is on medication, indicate behavior OFF medication with a circle (O) and ON medication with a square (), if known.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Behavior** | **Never** | **Occasionally** | **Often** | **Very Often** |
| Does not pay attention to details or makes careless mistakes | 0 | 1 | 2 | 3 |
| Has difficulty keeping attention to what needs to be done | 0 | 1 | 2 | 3 |
| Does not seem to listen when spoken to directly | 0 | 1 | 2 | 3 |
| Does not follow through when given directions and fails to finish *(not due to refusal or misunderstanding)* | 0 | 1 | 2 | 3 |
| Has difficulty organizing tasks and activities  | 0 | 1 | 2 | 3 |
| Avoids, dislikes, or does not want to start tasks requiring ongoing mental effort | 0 | 1 | 2 | 3 |
| Loses things necessary for tasks or activities *(assignments, pencils books)* | 0 | 1 | 2 | 3 |
| Is easily distracted by noises or other stimuli | 0 | 1 | 2 | 3 |
| Is forgetful in daily tasks  | 0 | 1 | 2 | 3 |
|  |
| Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| Leaves seat when remaining seated is expected | 0 | 1 | 2 | 3 |
| Runs about or climbs too much when not appropriate  | 0 | 1 | 2 | 3 |
| Has difficulty playing or beginning quite play activities | 0 | 1 | 2 | 3 |
| Is “on the go”or often acts as if “driven by a motor” | 0 | 1 | 2 | 3 |
| Talks constantly  | 0 | 1 | 2 | 3 |
| Blurts out answers before questions have been completed | 0 | 1 | 2 | 3 |
| Has difficulty waiting his/her turn | 0 | 1 | 2 | 3 |
| Interrupts or intrudes on others’ conversations and/or activities  | 0 | 1 | 2 | 3 |
|  |
| Argues with adults | 0 | 1 | 2 | 3 |
| Easily loses temper | 0 | 1 | 2 | 3 |
| Actively defies or refuses to go along with adults’ request or rules | 0 | 1 | 2 | 3 |
| Deliberately annoys people | 0 | 1 | 2 | 3 |
| Blames others for his/her mistakes or behaviors | 0 | 1 | 2 | 3 |
| Is touchy or easily annoyed by others  | 0 | 1 | 2 | 3 |
| Is angry or resentful  | 0 | 1 | 2 | 3 |
| Is spiteful and wants to get even  | 0 | 1 | 2 | 3 |
|  |
| Bullies, threatens, or intimidates others  | 0 | 1 | 2 | 3 |
| Starts physical fights | 0 | 1 | 2 | 3 |
| Lies to get our of trouble or to avoid obligations (i.e. “cons” others) | 0 | 1 | 2 | 3 |
| Is truant from school (skips school) without permission  | 0 | 1 | 2 | 3 |
| Is physically cruel to people  | 0 | 1 | 2 | 3 |
| Teacher Behavior Rating Scale Initial (continued) |
| **Behavior** | **Never** | **Occasionally** | **Often** | **Very Often** |
| Has stolen things that have value | 0 | 1 | 2 | 3 |
| Deliberately destroys others’ property  | 0 | 1 | 2 | 3 |
| Does not follow through when given directions and fails to finish | 0 | 1 | 2 | 3 |
| Is physically cruel to animals | 0 | 1 | 2 | 3 |
| Has deliberately set fires to cause damage | 0 | 1 | 2 | 3 |
| Has broken into someone else’s’ home, business, or car | 0 | 1 | 2 | 3 |
| Has stayed out late at night without permission  | 0 | 1 | 2 | 3 |
| Has run away from home overnight | 0 | 1 | 2 | 3 |
| Has forced someone into sexual activity  | 0 | 1 | 2 | 3 |
|  |
| Is fearful, anxious, or worried | 0 | 1 | 2 | 3 |
| Is self-conscious or easily embarrassed | 0 | 1 | 2 | 3 |
| Is afraid to try new things for fear of making mistakes | 0 | 1 | 2 | 3 |
| Feels worthless or inferior  | 0 | 1 | 2 | 3 |
| Blames self for problems, feels guilt | 0 | 1 | 2 | 3 |
| Feels lonely, unwanted, or unloved; complains that “no one loves them” | 0 | 1 | 2 | 3 |
| Is sad, unhappy, or depressed | 0 | 1 | 2 | 3 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Performance** | **Problematic** | **Somewhat Problematic** | **Average** | **Above Average** | **Excellent** |
| Overall School Performance  | 1 | 2 | 3 | 4 | 5 |
| 1. Reading
 | 1 | 2 | 3 | 4 | 5 |
| 1. Writing
 | 1 | 2 | 3 | 4 | 5 |
| 1. Math
 | 1 | 2 | 3 | 4 | 5 |
| Overall Home Behavior | 1 | 2 | 3 | 4 | 5 |
| 1. Relationship with parents
 | 1 | 2 | 3 | 4 | 5 |
| 1. Relationship with siblings
 | 1 | 2 | 3 | 4 | 5 |
| 1. Relationship with peers
 | 1 | 2 | 3 | 4 | 5 |
| 1. Participation in organized activities (e.g. games)
 | 1 | 2 | 3 | 4 | 5 |
| 1. Homework completion
 | 1 | 2 | 3 | 4 | 5 |
| 1. Organizational skills
 | 1 | 2 | 3 | 4 | 5 |

|  |
| --- |
| Comments: |

**Please return this form to the address or fax number on the first page.**

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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.