Dear Parents of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order for us to appropriately schedule an appointment for your child, we will need the following information. This information will help us determine the most appropriate appointment for your child. Once this information is received, we require up to 14 weeks to review. Based upon review of this intake packet we will contact you to make an appointment. *If it is determined that your child’s needs are best served elsewhere, we will try to direct you towards the appropriate resources*. Please **submit** the following with the completed packet:

Early intervention reports/evaluations

Custody Paperwork (if applicable)

Referral from primary pediatrician/PCP

*\*Incomplete forms will be returned for completion, which will lead to a delay in processing. If you need help completing the form, please contact our office. \**

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

**\*Due to the high demand of Developmental Pediatricians within our community, if your child has been evaluated by another Developmental Pediatrician prior to their scheduled appointment with our office, the referral will have been completed and we will be canceling 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**
* **UMPC For You**
* **Aetna Better Health**
* **Populytics**
* **Cigna (unless plan allows for out of network coverage)**

**\*Please know that if your child is scheduled to be evaluated in our office and their insurance is changed to any of the insurance plans listed above, we will need to cancel their appointment.***If you have private insurance or are self-pay, full payment is expected at the time of service to keep your scheduled appointment.*

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 and indicate if there are separate living conditions):

 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) | Gender | Age | Date of Birth | Medical or Behavioral Issues | Lives in the home |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

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

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

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

What are your concerns for your child?

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

**Reason for Visit**

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

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

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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 you are seeking a second opinion: who did you see?:(Please send in a copy of the initial assessment): |

|  |
| --- |
| **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** |
| Speech delay (ex: make sounds, babble, understand words, say words) |  |  |  |
| Fine motor delay (ex: grab or hold items in hands) |  |  |  |
| Social difficulties (ex: smile, play, point, gestures) |  |  |  |
| Gross motor delay ( ex: roll, sit, crawl, walk) |  |  |  |
| Moodiness or irritability, anxious child |  |  |  |
| Situational stressors (ex: family changes, neglect, abuse) |  |  |  |
| Sleep difficulties |  |  |  |
| Behavioral challenges (aggression, hyperactive) |  |  |  |
| Abnormal movements  |  |  |  |
| Feeding difficulty |  |  |  |

|  |
| --- |
| **Day Care Information** |
| Does your child attend daycare/homecare? o Yes o No |
| Current Day Care: |  |
| Address: |  |
| Contact numbers: | Phone: | Fax: |
| Teacher Name(s): |  |
| Has your child ever been expelled or suspended? oYes o NoIf yes, please describe the circumstances:  |

|  |  |
| --- | --- |
| **Has you’re child been evaluated by the following?** | **Age at Evaluation** |
| Early Intervention | o Yes  | o No |  |
| Do you have your child’s Individualize Family Service Plan (IFSP) or Individualized Educational Plan ( IEP)? | o Yes  | o No |  |
| \*\*If yes, we will require a copy of the evaluation and IEP before scheduling |

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| **Does your child currently receive any support services in school? Please check all that apply** |
| o | Case management | o | Special Instruction (SEIT) |
| o | Speech therapy | o | Early Head Start |
| o | Occupational Therapy | o | Children and Youth ( CYS) |
| o | Physical Therapy | o | Services for the Deaf |
| o | Services for the Blind | o | Other:  |

**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 Disorders |  |  |  |
| 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 |  |  |  |
| Other Conditions/Diagnoses – 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?** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| 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 | Yes | No |  |  |  |
| Neurologist | Yes | No |  |  |  |
| Eye doctor (Ophthalmology) | Yes | No |  |  |  |
| Hearing (Audiology or ENT) | Yes | No |  |  |  |
| Pulmonologist  | Yes | No |  |  |  |
| Cardiology  | Yes | No |  |  |  |
| Surgery  | Yes | No |  |  |  |
| Speech Therapist | Yes | No |  |  |  |
| Occupational Therapist | Yes | No |  |  |  |
| Physical Therapist | Yes | No |  |  |  |
| Feeding Therapist | Yes | No |  |  |  |
| Other: | Yes | No |  |  |  |

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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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **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? If yes Circle one : Audiology or ENTIf yes, date done:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Pregnancy, Labor and Delivery History** | **Yes** | **No** | **Comment** |
| Name or place of hospital your child born in? |  |  |  |
| 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? \_\_\_\_  |  |  |  |

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| --- |
| **Any Hospitalizations or Surgeries?** |
| **Date** | **Reason** | **Location** |
|  |  |  |
|  |  |  |
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| --- |
| **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? |  |  |  |
| Problems with eyes or vision? |  |  |  |
| Problems with hearing? |  |  |  |
| Motor tics (blinking, head tilts, arm movements, etc.)? |  |  |  |
| Vocal tics (sniffing, grunting, throat clearing, etc.)? |  |  |  |
| 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? |  |  |  |
| Thyroid or hormone problems? |  |  |  |
| Loose or floppy body? |  |  |  |
| **Current or Past Medical Symptoms (Continued)** |
|  | **Yes** | **No** | **Comments** |
| Rigid/stiff body? |  |  |  |
| Birth marks? |  |  |  |
| Skin problems? |  |  |  |
| Are immunizations up-to-date? |  |  |  |
| Unusual reaction to immunizations? |  |  |  |
| Known exposure to toxic chemicals or poisons? |  |  |  |
| **Development History** |
|  | **Approximate Age Accomplished** |
| Sat without support |  |
| Crawl  |  |
| Walked |  |
| Spoke first words (except mama/dada) |  |
| Spoke in two-three word sentences |  |
| Toilet training |  |
| Help getting dressed |  |
| 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: |

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| **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? |

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| **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? |  |  |  |
|  |  |  |  |

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| **Sleep History** |
|  | **Yes** | **No** | **Comments** |
| Does your child have trouble falling asleep? |  |  |  |
| Does your child have trouble staying asleep/night walking? |  |  |  |
| Does your child have early morning waking’s? |  |  |  |
| Does your child snore? |  |  |  |
| Does your child have difficulty waking in the morning? |  |  |  |
| Does your child have daytime fatigue? |  |  |  |
| Does your child have frequent nightmares? |  |  |  |
| Does your child have any night terrors or sleep walking? |  |  |  |
| Where does your child sleep? |  |  |  |
| Other concerns: |  |

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| **Nutrition/Diet** |
|  | **Yes** | **No** | **Comments** |
| Any history of or current feeding/eating difficulties? |  |  |  |
|  |  |  |  |
| 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:  |
| Fruits: |
| Vegetables: |
| Type of infant or toddler food:  |
| **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?** | **#bottle or Cups/day** | **Comments** |
| Breast milk or formula  |  |  |
| Milk |  |  |
| Water |  |  |
| Juice |  |  |
| Soda/sugar-sweetened drinks |  |  |

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| **Safety** |
|  | **Yes** | **No** | **Please explain** |
| Does child place non-food items in mouth more than other children that are the same age? |  |  |  |
| 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 (neglect, emotional, physical, and/or sexual)? |  |  |  |

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