Please align Patient Label with bottom line for auto filing.

University Health System

Pediatric Developmental Clinic Intake Form

Child's name:___________________________________
Child's MRN:___________________________________

Dear Parents/Caretakers,

Your child has a consultation to see a developmental pediatrician. **If your child had any previous evaluations, we need copies of those reports**. Examples include testing by schools, Early Intervention, occupational therapists, and speech-language pathologists. Likewise, if your child has seen **other specialists**, we need their reports. Examples include psychiatrists, psychologists, developmental pediatricians, child neurologists, geneticists, and endocrinologists. Radiology studies (CT or MRI scans) and laboratory test results (chromosomal analysis, genetic tests) are important. If your child is adopted, we would appreciate a copy of his/her birth records.

You must complete and return all 9 pages of this questionnaire to and copies of all the testing described above to the Developmental Nurse before we schedule your child's appointment with the doctor. Please **do not** mail anything to us, as that will cause delay. **Please send to email: pedidev@uhs-sa.com or fax to (210) 702-4248.**

Primary Care Physician (PCP) name: ____
Clinic name: ____

Person completing this form: ____ Today's Date: ____________________
Relationship to Child: ☐ Mother ☐ Father ☐ Other: ____

Please state your CONCERNS about your child. Why are you seeing a developmental pediatrician? Why did a provider consult us?

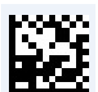
How long have you been concerned *or* when did someone first bring this to your attention? ______________
Since then, these problems: ☐ have improved ☐ not changed much ☐gotten worse
Has anyone evaluated your child for this? ☐ No ☐ Yes Explain/describe: _________________________

TEMPERAMENT CHARACTERISTICS

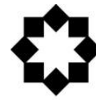
Please describe your **child's traits**. *Most of the time,* my child experiences and responds to the environment as follows:

- ***Overall Mood:***	☐ Cheerful[ES] (Mr/Ms Sunshine, looks on bright side)	☐ In between[S]	☐ Gloomy[D] (broods, mopes, never smiles)
Disposition:	☐ Calm (nothing fazes him/her, always relaxed)	☐ In between	☐ High strung (worry wart, always tense)
Consistency:	☐ Stable (steady and even-tempered)	☐ In between	☐ Moody (is fine then "snaps", good/bad days for no reason)
Sensitivity:	☐ Low (takes things in stride)	☐ In between	☐ High (feelings easily hurt, cries over anything)
Sociability:	☐ Outgoing (easily makes new friends)	☐ In between	☐ Shy, timid (won't say hello, doesn't join in activities)
Expression:	☐ Expressive (very demonstrative, open)	☐ In between	☐ Reserved (hard to read, never know how he/she feels)
- ***Initial Response:*** (How does child react in *new* or *unfamiliar* situations?)			
	☐ Enthusiastic/jumps right in	☐ Approaches	☐ Withdraws/avoids[S]
- ***Anger Expression***	☐ Slow to anger (can't get a rise out of him/her)	☐ In between	☐ Hot-tempered (easily upset, sort fuse)
Self-Control	☐ Deliberate, thoughtful (very patient)	☐ In between	☐ Impulsive (interrupts, acts before thinking)
Intensity	☐ Low key, laid back (quiet)	☐ In between	☐ Loud, forceful (overwhelming)
- ***Activity Level:***	☐ Low to moderate[S] (slow moving, sits quietly long time)	☐ In between	☐ Very high (restless, cannot sit still, always on the go)
- ***Concentration:***	☐ Focused, long attention span, listens well	☐ In between	☐ Distractible (tunes you out, forgetful, disorganized)
- ***Regularity/rhythmicity:*** (Sleeping, hunger, eating, toileting)			
	☐ Regular[E] (predictable, like a clock)	☐ In between	☐ Irregular[D] (erratic, unpredictable)
- ***Adaptability to change:***			
	☐ Good[E] (transitions easily, goes with the flow)	☐ In between	☐ Poor[DS] (upset by changes, very rigid, can't switch gears)
- ***Sensory threshold*** to touch, taste, smell, sound, pain, and light:			
	☐ High (sleeps through anything)	☐ In between	☐ Low (bothered by bright lights, clothing doesn't feel right)
- **Negative *Persistence:***			
	☐ Cooperative, malleable (knows when to stop)	☐ In between	☐ Stubborn, resistant (wears you down, never gives up)
- **Positive *Persistence:***			
	☐ Goal focused (sticks to the job until done)	☐ In between	☐ Gives up easily (starts but does not finish tasks)

Adapted from "The Emotional Problems of Normal Children; How Parents Can Help and Understand" by Stanley Turecki MD and Sarah Wernick PhD



Please align Patient Label with bottom line for auto filing.



University Health System

Pediatric Developmental Clinic Intake Form

BEHAVIOR/ LEARNING/SOCIALIZATION

What are your child's **STRENGTHS**? What does he/she enjoy doing? At what is he/she especially good?

My child has **BEHAVIORAL issues** (e.g., "quirks", tantrums/meltdowns, physical aggression, harms others, injures self, hyperactive, impulsive, oppositional/defiant, refuses to comply, lies, fights, or argues). ☐ No ☐ Yes. EXPLAIN: Give details so that we understand your concerns.

***A**ntecedents (triggers)*: When, where, or with whom is this most likely to happen *before* or when these occur?

***B**ehaviors*: What, when, how often, duration, severity. Child has episode-free days: ☐ No ☐ Yes. If "yes", how long between episodes? ___

***C**onsequences:* What occurs *after* the behavior? What makes it better? What makes it worse?

How do you **discipline** your child? ☐ Reward good behavior ☐ Natural / Logical consequences ☐ Time out ☐ Talking about things ☐ Loss of privileges ☐ Spanking/smacking ☐ Other:

Is discipline effective (does it work)? ☐ Consistently ☐ Usually ☐ Sometimes ☐ Inconsistently ☐ Rarely

Do parents share in and agree with how to manage child behavior? ☐ Yes ☐ No, Explain:

Has your child's behavior created marital or family conflict? ☐ Yes ☐ No, Explain:

Does your child have difficulty **LEARNING** (e.g., doesn't "get it", needs repetition, can't remember, can't focus, distracted, off-task, poor comprehension, needs reminders, can't process multistep tasks, needs redirection, problems in specific school subjects).

EXPLAIN:

Does your child have difficulty **SOCIALIZING with same-aged peers** **<u>other than siblings or cousins</u>** (e.g., doesn't approach others, has few friends, acts "deaf", is overly shy, is avoidant, limited eye contact, clings to parents, cries if left at school, does poorly in groups, doesn't bring/show things to others, doesn't understand others' body language).

EXPLAIN:

BULLYING. Do adults or other children at home or school pick on, tease, taunt, scare, hurt, or bully your child on a regular basis? ☐ Yes ☐ No

Explain____

DEVELOPMENTAL HISTORY

DEVELOPMENTAL LEVEL. Currently, my child acts/behaves as if he/she is _____ months/years old

Have you ever been worried that your child's development was **slower** than it should be (i.e., **delayed**)? ☐ Yes ☐ No

Explain____

REGRESSION. Has your child ever had a skill established *for at least three months* and then **<u>completely</u> lost that skill** (e.g., child spoke in full sentences then became <u>nonverbal</u>, child walked independently then was <u>unable to walk</u>)? ☐ Yes ☐ No

If yes, did this loss occur: ☐ Rapidly (over a few days/weeks) ☐ Slowly (over a several weeks/months)

Explain____

FEEDING & ELIMINATION

INFANCY

Mom breastfed and/or pumped breast milk: ☐ Yes ☐ No If "yes" until _____ days / weeks / months / years of age.

My child took breast milk *exclusively* (i.e., <u>no</u> formula) ☐ Yes ☐ No

Challenges included ☐ Difficulty latching, sucking, swallowing ☐ Poor milk supply

My child takes/took formula: ☐ Yes ☐ No If "yes" ☐ Regular ☐ Special: ________________________. Why? ________________________

Challenges included ☐ Difficulty sucking, swallowing ☐ Required special/modified nipple or bottle

TRANSITIONS

My child began taking solids (e.g., rice cereal, baby food) at age _____ weeks/months

My child began eating table foods at age _____ months

My child weaned from breast/bottle to cup at age _____ months

My child handled these transitions ☐ well ☐ poorly Explain: ____

FEEDING CHALLENGES.

My child is a "picky" eater: ☐ No ☐ Yes describe: ____

These challenges began at age ____ weeks / months / years. This occurred ☐ suddenly ☐ gradually.

This occurred with: ☐ introduction of a new food or new food texture ☐ change in health, the home, family, or schedule

Since then, these feeding challenges have ☐ improved ☐ not changed much ☐ gotten worse

His/her preferred foods are ☐ consistent and unchanging or ☐ inconsistent and unpredictable day to day and week to week

During feedings, my child: ☐ *excessively* fidgets / squirms in seat ☐ is *excessively* distracted, inattentive, off task ☐ leaves seat ☐ walks around
☐ overstuffs his/her mouth ☐ swallows solid foods whole without chewing them properly ☐ rushes through meals
☐ refuses / cries / pushes food away / throws food / has tantrums
☐ chokes / gag / coughs / vomits / retches / has difficulty breathing
☐ when offered *preferred* foods ☐ when offered *non-preferred* foods

After feeding, my child: ☐ has loud / noisy / gurgly breathing ☐ chokes / gags / coughs / vomits / retches / complains of heartburn or chest pain

The above challenges occur: ☐ at home with all /some caretakers ☐ at daycare ☐ at school ☐ at others' homes ☐ in restaurants

☐ My child has/had growth faltering, failure to thrive, poor weight gain, underweight, or slow growth velocity

☐ My child has/had iron deficiency or iron-deficiency anemia

☐ My child is overweight, heavy, or obese

☐ My child *eats* non-food items (e.g., paper, dirt, ice, soap, lotion) [Note: do not check box if your child only *mouths* these items]

PARENTAL RESPONSE. We have tried the following strategies to deal with the above challenges:

☐ distraction during meals (e.g., games, TV) ☐ forcing ☐ skipping meals ☐ allowing child to drink more fluids
☐ rewards / "bribes" ☐ giving preferred foods ☐ feeding child when s/he requests food ☐ punishing
☐ coaxing ☐ high-calorie supplements (oil, butter, other) ☐ high-calorie / special formula ☐ make-up meals

ENVIRONMENT & SCHEDULE

Who feeds your child? ☐ Mom ☐ Dad ☐ Other family members ☐ School ☐ Daycare ☐ Nurse ☐ Other: ____________

My child self-feeds: ☐ Always ☐ Sometimes ☐ Never

My child feeds him/herself using: ☐ bottle ☐ fingers ☐ spoon ☐ fork

Mealtime and snack time are: ☐ pleasant & enjoyable ☐ unpleasant/stressful

My child's *meals* are at the following times: _________________________. We offer our child *snacks*: ☐ when he/she asks ☐ scheduled

My child *wakes at night* to feed: ☐ no ☐ yes. I/we respond to this by: ____

During meals, our family eats: ☐ separately ☐ together at table Electronics (TV / gaming systems/ computers) are: ☐ on ☐ off

During meals, my child eats: ☐ in highchair ☐ in booster seat ☐ in chair ☐ in wheelchair ☐ on our lap ☐ on floor ☐ on sofa ☐ walking around

I/we offer: ☐ the same food for everyone ☐ different foods based on preference

My child's best meal of the day is usually: ☐ breakfast ☐ lunch ☐ dinner

MEAL DURATION.

When offered *preferred* foods, my child takes _______ minutes to eat, and finishes meals: ☐ always ☐ most times ☐ sometimes ☐ rarely

When offered *non-preferred* foods, my child takes _______ minutes to eat, and finishes meals: ☐ always ☐ most times ☐ sometimes ☐ rarely

ROUTE. My child takes feedings by:

☐ *MOUTH*: ☐ breastfed ☐ bottle w/ regular nipple ☐ bottle w/ special nipple ☐ spouted ("sippy") cup ☐ straw ☐ regular cup

☐ *G-TUBE*: ☐ bolus gravity / drip ☐ bolus pump ☐ continuous pump (rate ____ cc per hour x ____ hours)

CORE DIET. During an average day, my child consumes the following.

My child eats ☐ gluten-free/casein-free ☐ low-sugar, preservative-free, or Feingold® ☐ vegetarian/vegan ☐ organic ☐ Paleolithic ☐ other:

(Liquids) ☐ breastfeeds ____ minutes per breast every ____ hours or ____ times per day; _____ times at night
☐ expressed breast milk ____ oz every ____ hours or ____ times per day ☐ fortified with _____________
☐ formula (which brand? ___________________) ____ oz every ____ hours or ____ times per day)
____ cups/oz whole / 2% / 1% / skim ☐ unflavored cow's milk ☐ chocolate cow's milk ☐ soy milk ☐ almond milk ☐ rice milk
____ cups/oz unflavored water ____ cups/oz fruit juice, vegetable juice, Hi-C®, Kool-Aid®, Gatorade®, Mio®, Crystal Lite®, tea, soda

(Solids) ____ fruits ____ vegetables ____ protein (meats, eggs, beans, peanut butter, cheese) ____ grains (pasta, bread, cereal, rice, corn, potato)

(Texture) ☐stage 1 baby food (liquid purée) ☐stage 2 baby food (thick purée) ☐stage 3 baby food (chunky) ☐whole / chopped table foods

DIETARY SUPPLEMENTS. We supplement our child's diet with:

☐ multivitamin (e.g., Flintstones®, Poly-vi-sol®) ☐ iron ☐ megavitamin ☐ B6/B12 ☐ calcium/magnesium/zinc ☐ omega-3 fatty acids/fish oil
☐ Thick-It® / SimplyThick® / Thick & Easy® / Thixx™ / rice cereal / potato flakes
☐ Carnation® Breakfast Essentials™ ☐ PediaSure® ☐ Ensure ® ☐ protein powder ☐ other: ______________________________
☐ *extra* butter / cream ☐ *extra* vegetable oil ☐ medium-chain triglyceride (MCT) oil
☐ Polycose® / Duocal® / Moducal® ☐ Fruit or vegetable extracts

BOWEL MOVEMENTS

Consistency: ☐ Loose/watery ☐ Soft/mushy/pasty ☐ Hard/firm*

Size/Shape: ☐ Tubes/torpedoes ☐ Small/Rabbit pellets ☐ Large/cannonballs ☐ Has plugged toilet with stools (*not* toilet paper)*

Frequency: My child has a BM ______ times per day/week.

Other: ☐ Abdominal pain relieved with BM ☐ "Racing stripes" in underwear ☐ Incomplete evacuation/multiple tries
☐ Anal fissures/bleeding ☐ Crying/pain* ☐ Failed attempts ☐ Accidents: BM on floor/in clothing* ☐ Avoids/refuses defecation*

\

Please align Patient Label with bottom line for auto filing.

University Health System

Pediatric Developmental Clinic Intake Form

SLEEP

SLEEP As an infant, my child ☐ Slept well ☐ Slept poorly

We have an established *bedtime routine* for our child: ☐ No ☐ Yes (if you checked "Yes", please answer the next three bullets)

- During the 60 minutes *before* bedtime, our family does the following activities: ____
- My child's bedtime routine starts at _______ p.m. on weekdays or schooldays. The bedtime routine lasts ________ minutes / hours.
- My child's bedtime routine consists of: ____

My child has the following in his/her bedroom: ☐ TV/DVD/Blu-ray ☐ computer/tablet/mobile phone ☐ gaming system ☐ CD, radio, MP3

We give our child the following sleep remedy at _____ pm: ☐ melatonin ☐ Benadryl® ☐ clonidine ☐ trazodone ☐ other: _______________

We try to *put our child to bed* at _____ p.m. on weekdays or schooldays. We are consistent about his/her bedtime: ☐ Yes ☐ No

My child *falls asleep*:

☐ with the TV/radio/MP3 player on ☐ reading/using mobile phone/using tablet ☐ with overhead/hall/night light on ☐ with a pacifier/cup/bottle

☐ on the couch/sofa/floor ☐ alone in his/her bed/crib ☐ in bed with sibling ☐ in parent's bed ☐ in parent's arms/lap

After falling asleep, my child: ☐ remains where he/she fell asleep ☐ sleeps in the following location: ______________________________

He/she *usually* takes _________ minutes/hours to falls asleep. This is consistent: ☐ Yes ☐ No

He/she *usually* falls asleep at _______ p.m. This is consistent: ☐ Yes ☐ No

If your child takes longer than 30 minutes to fall asleep or if bedtime is a "battle", describe: ____

How do you respond to this? How do you get your child to fall asleep? ____

After our child falls asleep, other household members do the following activities: ____

After falling asleep, my child does the following: ☐ Has sleep terrors ☐ Has nightmares ☐ Kicks, thrashes, or moves constantly

☐ Wakes up_____ times per night He/she is awake for ______ min/hr This occurs _____ nights per week/month

☐ Leaves his/her bed and ☐ eats ☐ drinks ☐ plays ☐ Hops into someone else's bed ☐ Stays in someone else's bed

My child sleeps: ☐ sitting up in bed ☐ with head elevated ☐ with head tilted back

My child has/does the following: ☐ Night sweats (i.e., *soaks* sheets) ☐ Wets bed after age 6 or 7 years

☐ Breathes heavily/loudly Snores ☐lightly ☐loudly Snores ☐rarely ☐some ☐most nights ☐ Gasps, pauses, or struggles to breathe

My child *wakes*: Weekdays/schooldays at_____ a.m. Weekends/holidays at _____ a.m. If later on weekends, up later night before? ☐ Yes ☐ No

☐ easily / on his/her own ☐ with an alarm ☐ with difficulty / only if we wake him/her ☐ with a headache ☐ oversleeps if allowed

In the following mood: ☐ good/pleasant ☐ quiet/neutral ☐ irritable/angry

During the day: My child takes ______ naps. Naps last ______ minutes/hours. He/she wakes up from the last nap at ______ a.m./p.m.

☐ Falls asleep in school bus / at school / in car or drives fewer than 20 minutes ☐ Feels tired, yawns often, or falls asleep at school

FOR CLINIC USE ONLY. TOTAL SLEEP: ______ hrs. RECOMMENDED SLEEP: __________ hrs. SLEEP DEFICIT: ________ hrs.

AGE	*0 – 3 mo*	*4 – 11 mo*	*1 – 2 yr*	*3 – 5 yr*	*6 – 13 yr*	*14 – 17 yr*	*18 – 25 yr*
Recommended	14 – 17 hr	12 – 15 hr	11 – 14 hr	10 – 13 hr	9 – 11 hr	8 – 10 hr	7 – 9 hr
May be Appropriate	11 – 19 hr	10 – 18 hr	9 – 16 hr	8 – 14 hr	7 – 12 hr	7 -11 hr	6 – 11 hr

THERAPY/ SCHOOL/EXTRACURRICULAR ACTIVITIES

THERAPY

My child receives / received **therapy or services**: ☐ Yes ☐ No ☐ If in past only, dates: from _______ to _______

- If yes, is it ☐ Occupational therapy (OT) ☐ Physical Therapy (PT) ☐ Speech Therapy (ST) ☐ Vision Therapy

☐ Applied Behavior Analysis (ABA) ☐ Developmental Specialist ☐ Mental Health/Psychology/Social Worker

- My child receives therapy at ☐ Home ☐ Daycare/School ☐ Clinic/Office
- The therapy provider is ☐ Early Childhood Intervention (ECI) _____________________. ☐ Private company ____________________
- Each therapy session lasts ________ minutes. My child receives this therapy ________ times per week/month.
- My child began this therapy _________ weeks/months/years ago
- I feel that therapy is helping ☐ Yes ☐ No. Why not? ____

SCHOOL

Our family resides in the ____ Independent School District

My child attends ☐ private/home daycare ☐ group daycare ☐ Mother's Day Out/playgroup ☐ preschool / PPCD

☐ public school ☐ private school ☐ home school ☐ homebound public school

My child is in _____ grade at ____ School

His/her classroom has (please indicate number of each): __ general education teachers, __ special education teachers, __ aides, and __ students

School Screening: Hearing ☐ Pass ☐ Fail Vision ☐ Pass ☐ Fail

My child was retained a grade or held back: ☐ Yes ☐ No Which grade? _______ Why? ________________________________

My child has difficulty with the following subjects: ☐ reading ☐ writing ☐ spelling ☐ mathematics

My child advanced a grade, is in gifted/talented program, or takes AP/IB classes: ☐ Yes ☐ No If yes, explain: _________________________

My child has the following: ☐ IEP/ARD (i.e., special ed) or ☐ 504 Plan (accommodations & modifications) or ☐ Response to Intervention (RTI)

He/she qualifies for this under the **school classification** of: ____

☐ Resource room ☐ ALE ☐ Content mastery ☐ Self-contained classroom ☐ Social skills training

☐ Behavior Intervention Plan (BIP) ☐ Aide ☐ Tutoring ☐ Sylvan®, Huntington®, Kumon® or other learning center

My child's *typical* grades are ☐ A ☐ B ☐ C ☐ D ☐ F ☐ Proficient ☐ Satisfactory ☐ Unsatisfactory

My child's *current* grades are ☐ the same ☐ better than usual ☐ worse than usual

Organizational challenges. My child's assignments are frequently: ☐ late ☐ incomplete ☐ missing/lost
My child does **homework** at ☐ school ☐ home ☐ other: ________________________
It takes my child _____ minutes/hours to complete homework. Describe any *problems* during homework: ______________________________
I meet with my child's teachers every __________ days / weeks / months
Has your child ever been suspended or expelled from school/daycare? ☐ Yes ☐ No Explain: ___________________________________
Describe current school problems and what you are doing to improve them: ____
Are you happy with the current school and/or therapy setting? ☐ Yes ☐ No Explain: ___________________________________
Have you had difficulty accessing services for your child? ☐ Yes ☐ No Explain: ___________________________________

EXTRACURRICULAR ACTIVITIES My child is/was involved in: ____
He/she enjoys/enjoyed these activities: ☐ Yes ☐ No He/she does/did ☐ Well ☐ Average ☐ Poorly

PREGNANCY HISTORY

☐ **Unknown or limited (child was adopted)**
Mother's age *at delivery:* _______ years. Which pregnancy number was this for Mom (e.g., 1st, 2nd, 3rd, etc.)? ___________
Miscarriages or other problems *before this pregnancy:* ____
This pregnancy was: ☐ planned ☐ unplanned.
Conception occurred: ☐ naturally ☐ with assisted reproductive technology (e.g., in vitro fertilization, artificial insemination): ______________
Month of pregnancy when Mom began prenatal care (e.g., 1st, 2nd, etc.): ___________
Mother's health during pregnancy: ☐ Good ☐ Fair ☐ Poor Explain: ________________________________
Weight gained during pregnancy: _________ lbs

Did mother drink beer, wine, wine coolers, liquor, or use drugs in the month *prior to* discovering pregnancy? ☐ Yes ☐ No
Please indicate amount of alcohol, illicit drugs, or cigarettes used *during* pregnancy:

	Amount and Frequency	Month(s) of Pregnancy
Beer, wine, wine cooler, hard liquor	___________________	___________________
Cigarettes	___________________	___________________
Illicit drugs, specify:	___________________	___________________

Please list ALL prescription *or* over-the-counter medications/remedies/herbals used *during* pregnancy:
____

Did mother have any of the following **during this pregnancy**?
☐ Vaginal bleeding or spotting
☐ Blood group (e.g., Rh factor or ABO) incompatibility
☐ Fever, rash, or infection Describe: ___________________
☐ *Abnormal* ultrasound, amniocentesis, stress test, etc.
☐ Seizures or convulsions
☐ Sexually transmitted infection (e.g., gonorrhea, Chlamydia, herpes)
☐ Depression. Did Mom take antidepressants? Please list above.
☐ High blood pressure, pre-eclampsia, eclampsia, or toxemia
☐ Poor weight gain or ☐ Excessive weight gain
☐ Oligohydramnios (too little amniotic fluid) or polyhydramnios (too much)
☐ Multiples (twins, triplets, etc.)
☐ Serious injury (e.g., motor vehicle accident, trauma) or surgery
☐ Hospitalization or ☐ bed rest. Why? ______________________
☐ Diabetes: ☐ Gestational ☐ Chronic (pre-pregnancy)
Controlled with: ☐ Diet ☐ Insulin ☐ Other medication
☐ Stresses, worries, absent parent
☐ Accidental trauma
☐ Family dysfunction/problems, spouse abuse, marital problems
☐ Changed or handled cat litter
☐ Other problems: ____
Baby's movements were (check one): ☐ Less than expected ☐ Average ☐ More than expected

BIRTH HISTORY

☐ **Unknown or limited (child was adopted)**

Length of pregnancy _________ weeks/months

Length of labor _______ hours

Labor was (check one) ☐ Easy, no problems ☐ Difficult (explain)

☐ Spontaneous (natural) ☐ Augmented ☐ Induced, Explain: _________________

Were there any of the following problems **during labor or delivery**?

☐ Premature rupture of membranes (water broke early)
☐ Maternal fever
☐ Abnormal/excessive vaginal/uterine bleeding
☐ Failure of labor to progress (baby wouldn't come down)
☐ Problem with placenta, Explain: __________________________
☐ Meconium in fluid (baby bowel movement)
☐ Nuchal cord (umbilical cord wrapped around neck)
☐ Other complications or problems (explain): ____

Baby's position: ☐ Head down (vertex) ☐ Legs, feet, or buttocks down (breech) ☐ Back/spine down (transverse lie)

Delivery was: ☐ Natural (vaginal) ☐ Forceps/vacuum assist ☐ Scheduled cesarean section ☐ Emergency cesarean section

Baby's Apgar scores, if known: ___/___ **Birth Weight ______lbs_____ oz Length: _______ in** Head circumference: _______ cm/in

FOR CLINIC USE ONLY. ☐ AGA ☐ SGA ☐ LGA

	24 wks	26 wks	28 wks	30 wks	32 wks	34 wks	36 wks	38 wks	39 wks	40 wks	42 wks
SGA	450 (1'0")	550 (1'3")	660 (1'7")	850 (1"14")	1400 (3'1")	1800 (3'15")	2250 (4'15")	2600 (5'12")	2750 (6'1")	2900 (6'6")	3200 (7'1")
LGA	920 (2'0")	1250 (2'12")	1630 (3'9")	2100 (4'10")	2300 (5'1")	2800 (6'3")	3300 (7'4")	3800 (8'6")	4000 (8'13")	4200 (9'4")	4650 (10'4")
Short	27.5 (10.8")	30.3 (11.9")	33 (13")	35.7 (14.1")	40 (15.7")	42.5 (16.7")	44.5 (17.5")	46.5 (18.3")	47.5 (18.7")	48.5 (19.1")	50 (19.7")
Tall	36.7 (14.4")	39.8 (15.7")	42.4 (16.7")	45 (17.7")	45.5 (17.9")	48 (18.9")	50 (19.7")	52 (20.5")	53 (20.9")	54 (21.3")	56 (22")
Micro	19 cm	21.2 cm	23 cm	25 cm	28 cm	29.5 cm	31 cm	32 cm	33 cm	33.5 cm	34.5 cm
Macro	25 cm	27.2 cm	32 cm	31.2 cm	29.2 cm	33.5 cm	35 cm	36 cm	37 cm	37.5 cm	38.5 cm

http://www.biomedcentral.com/1471-2431/3/13 Fenton. *BMC Peds* 2003;3:13

NEONATAL AND EARLY INFANCY HISTORY

Duration of mother's hospital stay _____ days Duration of baby's hospital stay _____ days/weeks/months

Newborn Hearing Screening: ☐ Passed ☐ Failed

Were there any of the following problems **while the baby was in the hospital**? (check)

☐ Baby was in Level II Nursery (Special Care) for _____ hours/days
☐ Baby was in Level III Nursery (NICU) for _____ hours/days/weeks/months
☐ Needed oxygen for _____ hours / days / weeks
☐ Transient tachypnea of the newborn (TTN)
☐ Respiratory distress syndrome (RDS) (immature lungs)
☐ Infections/meningitis/fever
　☐ IV antibiotics for ____ hours / days
☐ Feeding/sucking/latching problems
☐ Abnormal head ultrasound, CT, or MRI scan
☐ Blood transfusion/severe anemia
☐ Low blood sugar
☐ Birth defects: _________________________________
☐ Eye problems (retinopathy of prematurity, cataract, etc.)
☐ On ventilator (breathing machine) for _____ hours / days / weeks
☐ Seizures/convulsions
☐ Jaundice (yellow eyes and skin)
　☐ Phototherapy (blue lights) for ____ hours / days
☐ Abnormal muscle tone ("floppy" or "stiff")
☐ Bleeding into brain or ventricles (intraventricular hemorrhage)
☐ Temperature instability (placed in isolette or "incubator")
☐ Poor growth
☐ Heart problem: _________________________________ _____
☐ Required surgery: ______________________________________

Please explain:____
____
____

In the first six months, did baby have any of the following problems (check):

☐ Excessively quiet/sleepy
☐ Colicky/fussy/irritable
☐ Floppy (low muscle tone or hypotonic)
☐ Poor head control (excessive head lag)
☐ Did not like to be held/cuddled
☐ Difficult to calm down or soothe
☐ Other problems/concerns
☐ Excessively hyperactive or restless
☐ Difficult to feed (poor suck, spitting up, etc)
☐ Stiff (increased muscle tone or spasticity)
☐ Poor eye contact
☐ Abnormal response/interactions with people
☐ Sleep problems/snoring

Please explain: ____

How was your child's temperament (disposition, personality, or mood) and feeding during the first year?
____

Please align Patient Label with bottom line for auto filing.

University Health System

Pediatric Developmental Clinic Intake Form

MEDICAL HISTORY

My child has/had the following **chronic, ongoing conditions** that require care by a doctor or follow-up by a specialist:

☐ Autism spectrum disorder* ☐ ADHD/ADD ☐ Intellectual disability (IQ < 70) ☐ Learning disability (e.g., dyslexia)
☐ Developmental delay ☐ Hypotonia (low muscle tone) ☐ Cerebral palsy ☐ Epilepsy/seizure disorder
☐ Sensory integration dysfunction ☐ (Central) auditory processing disorder ☐ Genetic/chromosomal disorder: _____________
☐ Heart problem: _______________ ☐ > 6 ear infections per yr ☐ Hearing loss/deafness ☐ Eye/vision problems ☐ Dental problems
☐ Asthma / Allergies / Eczema ☐ Tracheostomy ☐ Kidney problems ☐ Feeding disorder ☐ Short stature
☐ Gastroesophageal reflux (GERD) ☐ Constipation ☐ Failure to thrive (poor weight gain) ☐ Gastrostomy tube (G-tube)

** (previously called "autistic disorder", "Asperger syndrome, or "PDD-NOS")*

Explain/Other: ____

Hospitalizations (<u>after</u> nursery/NICU): Date/Age Reason Hospital
☐ None
_______________________ ________________ _______________________
_______________________ ________________ _______________________
_______________________ ________________ _______________________

Operations/surgeries: Date/Age Reason Hospital
☐ None
_______________________ ________________ _______________________
_______________________ ________________ _______________________

Please explain: ____

Has your child ever had a serious **head injury** (e.g., concussion, "knocked out")? ☐ No ☐ Yes Explain: ______________________________

Has your child ever had a **broken bone** or required **sutures** ("stitches")? ☐ No ☐ Yes Explain: ____________________________________

MEDICATIONS

List **ALL *CURRENT* MEDICATIONS, HERBS, VITAMINS, or SUPPLEMENTS** your child takes **DAILY or LONG TERM (> 6 weeks)**

Medication Name	Dosage (mg, mL)	Time Given	How long on this medication?	For what is this medication given?	Benefits. How does it help?	Side effects

List **ALL MEDICATIONS, HERBS, VITAMINS, & SUPPLEMENTS** your child ***PREVIOUSLY*** took **DAILY or LONG TERM (> 6 weeks)**

Medication Name	Dosage (mg, mL)	Time Given	How long on this medication?	For what was this medication given?	Benefits. With what did it help? List side effects.	**Why did you stop using it?**

Has child ever had an **allergic reaction to a medicine** (e.g., lip swelling, large welts, and breathing problems)? ☐ No ☐ Yes
Explain: ____

Are **immunizations** up to date? ☐ No ☐ Yes Has child ever had a *life-threatening reaction* to an immunization? ☐ No ☐ Yes
Explain: ____

Please align Patient Label with bottom line for auto filing.

University Health System

Pediatric Developmental Clinic Intake Form

SOCIAL HISTORY

MOTHER'S NAME: ____ Age: _____ years
Occupation: _______________________ Education: ☐< HS ☐GED ☐HS ☐Tech ☐Some college ☐Associate's ☐Bachelor's ☐Master's ☐Professional
Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never married Number of marriages: _______

FATHER'S NAME: ____ Age: _____ years
Occupation: _______________________ Education: ☐< HS ☐GED ☐HS ☐Tech ☐Some college ☐Associate's ☐Bachelor's ☐Master's ☐Professional
Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never married Number of marriages: _______

Who lives at home with the child?
☐ Biological (birth) mother ☐ Biological (birth) father ☐ Other adult relative (e.g., grandparent, aunt, uncle, etc.)
☐ Stepmother ☐ Stepfather ☐ Foster parent(s) ☐ Adoptive parent(s)
☐ Biological (full) siblings ☐ Step-brother/sister ☐ Half-brother/sister ☐ Cousins, other children
Please list sibling's name(s) *and* age(s): ____

Does anyone living at or frequently visiting your home smoke tobacco products? ☐ Yes ☐ No

We have lived in ______________________________ (CITY), ____________________ (STATE) since __________ (MONTH) ________ (YEAR)

My child is in the following programs:
☐ SNAP ("Food Stamps") ☐ Respite Care ☐ Medicaid/SSI/MDCP ☐ Women, Infants, & Children (WIC)

Has Child Protective Services (CPS) or Family Advocacy Program (FAP) ever been involved with you or your family?
☐ No ☐ Yes If yes, please describe: ____

Does your family have any significant stressors or problems since your child was born or adopted?
☐ Moves ☐ Marital conflicts ☐ Illnesses/Death ☐ Sibling concerns
☐ Separations ☐ Divorces ☐ Alcohol/drugs ☐ Other concerns
☐ Family violence ☐ Abuse ☐ Financial Problems

REVIEW OF SYSTEMS

Please describe if your child has/had ongoing, recurrent, or frequent problems with any of the following *not described earlier* in this questionnaire.
☐ Neurological (brain, spinal cord, nerves). Explain:
☐ Ear, Nose, Throat. Explain:
☐ Respiratory (lungs). Explain:
☐ Problems with exercise: fainting / dizziness / chest pain / shortness of breath / exercise intolerance
☐ Coughing while sleeping / coughing during or after meals
☐ Cardiovascular
☐ Rheumatic fever
☐ Palpitations / rapid heart rate / extra or skipped beats
☐ High blood pressure
☐ Heart murmur other than innocent, functional, or Still murmur
☐ Gastrointestinal (if not previously mentioned in "bowel movements"). Explain:
☐ Genitourinary (kidneys, bladder, genitals). Explain:
☐ Endocrine (thyroid, glands, hormones). Explain:
☐ Eye. Explain:
☐ Musculoskeletal (joints, bones, muscles). Explain:
☐ Skin problems (rashes or lesions other than freckles, small moles, Mongolian spots, or "stork bites"). Explain:

Please align Patient Label with bottom line for auto filing.

University Health System

Pediatric Developmental Clinic Intake Form

FAMILY HISTORY

Does or did <u>anyone</u> in the family have <u>any</u> of the following? Use the following codes **<u>in relation to your child</u>**: **B** = brother; **S** = sister; **GF** = grandfather; **GM** = grandmother; **AU** = aunt; **UN** = uncle; **C** = 1st cousin. (Example: GF under the "Mother's Family" column would indicate your child's maternal grandfather has/had a problem). PLEASE DESCRIBE OR GIVE DETAILS!

Check these boxes <u>only</u> if Mom or Dad has/had the condition!

Condition	**Birth Mother**	**Birth Father**	**Child's Sibling**	**Mother's Family**	**Father's Family**
Miscarriages	☐	N/A	__________	_____________	______________
Developmental delay (e.g., speech)	☐	☐	__________	_____________	______________
Learning disability (dyslexia)	☐	☐	__________	_____________	______________
ADHD (Sometimes called "ADD")	☐	☐	__________	_____________	______________
Intellectual disability (IQ < 70) (Previously called "mental retardation")	☐	☐	__________	_____________	______________
Autism spectrum disorder (Previously called "autistic disorder", "Asperger syndrome", or "PDD-NOS")	☐	☐	__________	_____________	______________
Failure to graduate high school (Did this person go on to get a GED or a college degree?)	☐	☐	__________	_____________	______________
Aggressive/violent/abusive	☐	☐	__________	_____________	______________
Anxiety d/o / panic attacks	☐	☐	__________	_____________	______________
PTSD (post-traumatic stress disorder)	☐	☐	__________	_____________	______________
Obsessive-compulsive disorder	☐	☐	__________	_____________	______________
Tics or Tourette syndrome	☐	☐	__________	_____________	______________
Bipolar disorder	☐	☐	__________	_____________	______________
Depression (<u>Please</u> specify if situational, post-partum, or chronic)	☐	☐	__________	_____________	______________
Eating or feeding disorder	☐	☐	__________	_____________	______________
Psychosis/schizophrenia	☐	☐	__________	_____________	______________
Victim of abuse	☐	☐	__________	_____________	______________
Alcohol abuse	☐	☐	__________	_____________	______________
Drug abuse	☐	☐	__________	_____________	______________
Suicide attempt/completion	☐	☐	__________	_____________	______________
Psychiatric hospitalization	☐	☐	__________	_____________	______________
Legal, arrests, delinquency	☐	☐	__________	_____________	______________
Heavy/overweight/obese	☐	☐	__________	_____________	______________
Obstructive sleep apnea (Does this person require CPAP, BiPAP, or oxygen?)	☐	☐	__________	_____________	______________
Heart problems (**<u>Only</u>** include heart attack before age 35 years, sudden death, rhythm disorder, event requiring resuscitation before age 35 years, Marfan syndrome)	☐	☐	__________	_____________	______________
Sudden *unexplained* death (e.g., SIDS, SUDS, SUDEP)	☐	☐	__________	_____________	______________
Genetic/chromosomal disorder	☐	☐	__________	_____________	______________
Birth defects	☐	☐	__________	_____________	______________
Gland problems (e.g., thyroid)	☐	☐	__________	_____________	______________
Dementia (e.g., Alzheimer)	☐	☐	__________	_____________	______________
Seizures/convulsions/epilepsy	☐	☐	__________	_____________	______________
Cerebral palsy	☐	☐	__________	_____________	______________
Parkinson, tremors, shakes	☐	☐	__________	_____________	______________
Deafness or blindness	☐	☐	__________	_____________	______________

Last updated 12/5/2016