

PLEASE COMPLETE ENTIRE APPLICATION



Developmental & Behavioral Pediatrics of the Carolinas

Today's Date: _____

Child's Name: _____

DOB: _____

PATIENT HISTORY FORM

Person completing this Form: _____ Relationship to Child: _____

Name Child wants to be called: _____

PURPOSE OF THE VISIT

Describe what concerns you have about your child: _____

Previous Evaluations for these concerns: _____

(Examples: School, CDSA, Psychiatrists, Neurologists, Genetics)

What would you most like to happen with this visit: _____

What questions do you have for the doctor: _____

List any services your child is currently receiving: _____

(Speech, Occupational Therapy, Physical Therapy, ABA, include special services through the school, 504, Exceptional Children Services, special classroom)

Does he/she currently have * Individual Educational Program (IEP)? Y/N? _____ a Section 504 Plan? Y/N? _____

If your child has been on any medications in the past, list with dose and reactions:

_____	_____
_____	_____
_____	_____
_____	_____

CHILD'S HISTORY

Describe Your Child's Health: _____

Birth Weight: _____

Complications at Birth: _____

Current Medications (Name and Dose): _____

_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies: _____

Hospitalizations: _____

Surgeries: _____

Extended Illnesses: _____

Significant Injuries: _____

Describe Your Child's Growth: _____

Describe Your Child's Temperament: _____

When did your child begin school or preschool: _____ Repeated Grade: _____

Current School: _____ Grade: _____

DEVELOPMENTAL HISTORY:

Describe what developmental concerns you have: _____

At What Age did you first suspect difficulties: _____

By what age did your child do the follow things?

MOTOR

Crawl: _____

Sit without support: _____

Walk alone: _____

Ride a tricycle: _____

Ride a bicycle with training wheels: _____

Ride a bicycle without training wheels: _____

LANGUAGE

Babble: _____

Said first word: _____

Put 2 words together: _____

SOCIAL/SELF HELP

Smile: _____

Use a spoon to feed self: _____

Bladder trained Day: _____

Bladder trained Night: _____

Bowel trained: _____

Able to separate from Mom easily: _____

Able to dress oneself: _____

In the list below, please circle any of these issues your child has had.

Shyness with strangers

Refusal to go to school

Extreme restlessness

Trouble getting satisfied

Over reaction to sights or noises

Temper tantrums

Crying often and easily

Head Banging

Trouble with eye contact

Making odd sounds, grunts or other noises

Eating non-foods

Trouble falling asleep

Noisy breathing/snoring

Looseness or floppiness

Bashfulness with other children

Problems with change of daily routine

Tendency to be overexcited

Difficulty getting consoled

Extreme reaction to tastes or touching

Irritability

High tolerance for pain

Self destructive behaviors

Failure to be affectionate

Feeding difficulty

Colic

Trouble staying asleep

Stiffness or rigidity

REVIEW OF SYSTEMS

In the list below, please circle any of these problems your child has had.

- | | |
|------------------------------|--------------------------------|
| Chronic Pain | Unexplained Fevers |
| Weight Loss | Cancer |
| High Cholesterol | Cataracts |
| Crossed Eyes | Chronic Ear infections |
| Chronic Sinus Infections | Chronic Allergic symptoms |
| Heart Murmur | Other Heart Problems |
| Asthma | Bronchiolitis |
| RSV | High Blood Pressure |
| Chronic Bronchitis | Cystic Fibrosis |
| Other Lung Disorders | Chronic Diarrhea |
| Chronic Constipation | Reflux |
| Ulcer | Other stomach or bowel problem |
| Joint problems | Muscle Problems |
| Skin Problems | Chronic Eczema |
| ADHD | Learning Disabilities |
| Mental Retardation | Autism |
| Seizures | Cerebral Palsy |
| Depression | Anxiety |
| Kidney or Bladder infections | other kidney disease |
| Dabetes | Thyroid problems |
| Other glandular problems | Sickle Cell Anemia |
| Anemia | Other blood disease |
| Other _____ | Other _____ |

SOCIAL HISTORY:

PARENTS: () Married () Divorced () Separated () Other _____

Who does the child live with? _____

Child's Relationship with Mother: _____

Child's Relationship with Father: _____

Siblings, names and ages: _____

Family circumstances: _____

Biological Father:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health: _____

Biological Mother:

Name: _____ Age: _____
Present Occupations: _____ School level completed: _____
General Health: _____

Was the child adopted? _____ At what age? _____
Circumstances of Adoption: _____

Adoptive Father:

Name: _____ Age: _____
Present Occupations: _____ School level completed: _____
General Health: _____

Adoptive Mother:

Name: _____ Age: _____
Present Occupations: _____ School level completed: _____
General Health: _____

Has this child been in Foster Care? _____
Circumstances of Foster Care: _____
Foster Parents: _____
Total Number of foster placements? _____

FAMILY HISTORY:

Who in the family has any of the following difficulties? (Only include biological Family)
(This would include Child’s Father, Mother, Brothers, Sisters, Grandparents, Aunts, Uncles and first Cousins)

Please note next to the appropriate items the family member who had/has the problem

- | | |
|------------------------------|-----------------------------------|
| Hyperactivity: | Asperger syndrome: |
| Trouble Learning: | Bipolar Disorder: |
| Mental Retardation: | Schizophrenia: |
| Repeated a grade in school: | Other emotional problems: |
| Speech Problems: | Drinking or drug Abuse: |
| Behavior problems in school: | Birth Defects: |
| In trouble as a teenager: | Tics or Tourette ’s syndrome: |
| Depression: | Blind/severely visually impaired: |
| Anxiety: | Hearing Impaired: |
| ADHD: | Seizures: |
| Autism: | Died as Infant or Child: |