**Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had worries about abnormal or slow development in your child? Yes or No If yes, please describe at what age you first became concerned\_\_\_\_\_\_\_\_, and what symptoms made you worry about development:**

**Has your child ever lost developmental skills? Yes or NO If yes, please describe at what age the skills were lost and which skills were lost:**

**Has your child been given any diagnosis of a specific developmental problem or handicapping condition (for example cerebral palsy, learning disability)? Yes or No If yes, please describe:**

**Does your child receive any specialized developmental treatment services or special education program (for example, physical therapy or special classroom placement)? Yes or No If yes, please describe:**

**What is your child’s current educational placement? (School, grade level)?**

**FAMILY HISTORY: For each family member please list current age, medical problems, and if deceased, list cause and age of death.**

**Father AGE\_\_\_\_\_\_\_HEALTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother AGE\_\_\_\_\_\_HEALTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Siblings (brothers and sisters) SEX AGE HEALTH**

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

**Do any of the above family members, or more distant relatives, have any known neurological, psychiatric, or inherited conditions? (For example, seizures, migraines, muscle disease, diabetes) If yes, please describe**

**Please describe the patient’s current living arrangements. (Who lives in the home, and who provides primary child care).**

**Patients Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all past surgical procedures with estimated dates:**

**Please list any current medications, including doses and times given (including herbal medicine):**

**Does the patient have any allergies to medications? YES NO If yes, please list the medication and nature of the reaction.**

**BIRTH HISTORY:**

**What was the patient’s birth weight?\_\_\_\_\_\_\_\_\_\_\_lbs.\_\_\_\_\_\_\_\_\_\_\_Oz**

**Was the patient born prematurely? YES NO If yes, how many weeks premature.**

**Were there any problems during pregnancy? YES NO If yes, please describe.**

**Were there any problems during delivery? YES NO If yes, please describe.**

**Type of delivery: Vaginal or C-Section**

**Did the patient have any problems in the newborn period (first month of life)? YES NO If yes, please describe.**

**How long did your child stay in the hospital after birth?**

**DEVELOPMENTAL HISTORYL**

**Age at which: Rolled front to back\_\_\_\_\_\_\_\_Transferred objects hand to hand\_\_\_\_\_\_\_\_Sat alone\_\_\_\_\_\_ Walked independently \_\_\_\_\_\_\_Used first words appropriately\_\_\_\_\_\_Put 2 words together\_\_\_\_\_\_Pointed to body parts\_\_\_\_\_Talked in sentences \_\_\_\_\_\_\_\_ Identified colors \_\_\_\_\_\_\_\_ Counted to 10 \_\_\_\_\_\_\_\_Recognized letters\_\_\_\_\_\_\_\_**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief complaint: Please describe the reason for your appointment. List any questions you have for us and symptoms you wish us to evaluate. You may want to list specific conditions or diagnosis of concerns to you.

History of present illness: Please describe the problem in detail answering all the following questions:

What signs or symptoms is your child experiencing?

How long have these symptoms been present?

What part(s) of the body and what functions are being affected?

How often do these symptoms occur?

Do Symptoms occur at a particular time of the day? If so, when?

How severe is the problem?

How long do the symptoms last?

Does anything make the symptoms get better? If so, what?

Does anything make the symptoms get worse? If so, what?

Has there been prior treatment or surgery for this problem? If so:

What treatment?

By Whom?

What were the results of the treatment?

Please describe all other current medical problems and past medical illnesses?

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of systems: Please check any symptom or condition listed below, and describe details of these problems if present in the patient.

\_\_\_None

**General Health Gastrointestinal Chest, Heart and Lung Endocrine**

\_\_poor weight gain or loss \_\_vomiting or diarrhea \_\_Chest pain \_\_thyroid trouble

\_\_excessive weight gain \_\_poor appetite \_\_heart defect or murmur \_\_heat or cold intolerance

\_\_feeding problems \_\_abdominal pain or colic \_\_blood pressure problems \_\_excessive sweating

\_\_recurrent fevers \_\_bloody stools \_\_fainting \_\_diabetes

\_\_liver disease \_\_shortness of breath / wheezing \_\_excessive thirst/hunger

 \_\_food intolerance or allergies \_\_lightheadedness \_\_excessive frequency of urination/polyuria

**Skin, Musculoskeletal Head, Eyes, Ears, Nose, Throat Genito-Urinary Hematologic**

\_\_joint pain or swelling \_\_excessively large head \_\_urinary infections \_\_anemia

\_\_joint contractures \_\_excessively small head \_\_kidney disease \_\_easy bruising

\_\_limb deformities \_\_abnormal head shape \_\_blood in urine \_\_past transfusion

\_\_spine defects \_\_bulging soft spot \_\_painful urination \_\_swollen glands

\_\_back or neck pain \_\_swollen neck glands \_\_delayed or regressed toilet training \_\_autoimmune disease

\_\_skin rashes \_\_sinus problems or ear \_\_loss of bowel or bladder control

 infections

\_\_nose bleeds

**Neurological Neurological Behavioral/Emotional**

\_\_confusion \_\_difficulty sitting \_\_withdrawn \_\_personality change

\_\_excessive sleepiness \_\_difficulty standing/walking \_\_aggressive **Males**

\_\_headache \_\_hoarseness \_\_hyperactivity \_\_hernia

\_\_memory problems \_\_clumsiness or incoordination \_\_mood swings \_\_abnormal discharge

\_\_school failure or underachievement \_\_numbness \_\_sleep problems \_\_testicular pain or lumps

\_\_delayed speech development \_\_poor balance \_\_temper tantrums **Females**

\_\_vision problems \_\_stiffness in limbs \_\_breath holding spells \_\_menstrual problems

\_\_double vision \_\_weakness\_arms/legs \_\_depression \_\_vaginal infections

\_\_ringing in ears \_\_abnormal movement \_\_suicidal thoughts

\_\_trouble chewing or swallowing \_\_seizures \_\_hallucinations