SUNSHINE PEDIATRICS

Developmental Evaluation

INTAKE FORM

Child's name:	Child's birthday:
Child's address:	Child's phone:
What is your main concern for your child?	How old was your child when you became concerned? Why are/were you concerned?
Who suggested you have your child evaluated?	How are you related to the child?
Has your child been evaluated anywhere else for developmental concerns? If yes, please tell where: Name: Address: Phone:	What were you told at that time?

Has your child had any of the following? If so, please tell us the outcome.

Genetic testing:	Y_____ N_____	Normal_____	Abnormal_____	
MRI of the brain:	Y_____ N_____	Normal_____	Abnormal_____	
Amino acids:	Y_____ N_____	Normal_____	Abnormal_____	
Urine organic acids:	Y_____ N_____	Normal_____	Abnormal_____	
Hearing:	Y_____ N_____	Normal_____	Abnormal_____	Date_____
Vision:	Y_____ N_____	Normal_____	Abnormal_____	Date_____

Please list other doctors your child has seen:

Name: Specialty:

Address:

Phone:

Name: Specialty:

Address:

Phone:

Name: Specialty:

Address:

Phone:

Name: Specialty:

Address:

Phone:

Does your child attend school or daycare? Y___ N ____ If yes, please list the name:

School district where you live:_____

Grade: _____ Teacher: _____

Has your child repeated a grade? Y___ N ____ , if yes, please indicate which one(s)

_____

Who decided your child should repeat a grade? _____

_____

Has your child ever had educational testing from the school? Y ____ N _____ If yes, please state the outcome _____

_____

Have you ever been in a meeting (i.e IEP) with your child's teacher(s), principal, and/or other people from the school? Y _____ N _____ If yes, what was decided about your child?

_____

_____

Has your child ever been given a formal classification by the school? Y ___ N ___ If yes, please list:

_____

Has your child ever received special education services? Y _____ N_____ If yes: When did they begin?

_____

What services is he/she getting at school, how long (i.e. 30min 2x/week) and how often (i.e. once weekly, once monthly, etc.)? _____

_____

Has your child been seen or is currently being seen by the following:

1. Speech therapist? Name:	Currently_____ In the past_____
Location:	Phone:
2. Occupational therapist? Name:	Currently_____ In the past_____
Location:	Phone:
3. Physical therapist? Name:	Currently_____ In the past_____
Location:	Phone:
4. Psychologist? Name:	Currently_____ In the past_____
Location:	Phone:
5. Behavior specialist? Name:	Currently_____ In the past_____
Location:	Phone:

Please attach a list of additional therapists/psychologists with name, address, and phone number, If any.

During the pregnancy of this child, did the mother have any of the following?

□ High blood pressure _____

□ Diabetes _____

□ Weight loss _____

□ Too much vomiting _____

□ Weight gain of more than 50 pounds _____

□ Urinary infections _____

□ Sinus infections/colds _____

□ Low blood/low iron or anemia _____

□ Swelling of feet and legs _____

□ Help with getting pregnant (visiting a fertility specialist) _____

□ Surgeries (please list) _____

□ Depression/mood swings _____

□ Anxiety _____

□ Other _____

_____

During the pregnancy of this child, did the mother take any of the following?

□ Prenatal vitamins, folic acid, and iron _____

□ Thyroid medicine _____

□ Antibiotics _____

□ Blood pressure medicine _____

□ Insulin _____

□ Glucophage (Metformin®) _____

□ Tylenol _____ □ Cold medicine _____

□ Depression medicines _____

□ Anxiety medicines _____

□ Other _____

During the pregnancy of this child, did the mother use any of the following?

□ Tobacco cigarettes: _____cigarettes _____ packs each day

□ Chewing tobacco _____

□ Beer: _____ cans _____ cases each day □ Wine: _____ glasses each day

□ Hard liquor: _____ bottles _____ glasses each day

□ Marijuana joints _____ each day □ Cocaine _____ times each day

□ Heroin _____ times each day for _____ months _____ weeks

Did the mother take any street drugs with a needle? Y _____ N _____

DURING THE DELIVERY:

Mother had:	Baby had:
☐ Bleeding _____	☐ Trouble breathing _____
☐ High blood pressure _____	☐ Needed oxygen or tube to breathe:
☐ Fever_____	_____
☐ Seizure _____	☐ Difficulty coming through birth canal
☐ Epidural _____ No medicine _____	_____
☐ Needed a cesarean (c-section) section	☐ Did not cry immediately _____
_____	☐ Was blue _____
Reason: _____	☐ Was jittery _____
☐ Vacuum/forceps: _____	☐ Low muscle tone _____
☐ Pain with delivery: _____	☐ Heart murmur _____
☐ Other: _____	☐ Other _____

AFTER THE DELIVERY:

Hospital where baby was born: _____

Baby stayed in the hospital for _____ days in ____ nursery ____ NICU

Birthweight: _____

Delivery was at _____ weeks ____months

Baby needed:

☐ Ventilator for _____ days ☐ Oxygen for _____ days

☐ Echocardiogram/Heart rhythm test (EKG) _____

☐ Heart surgery _____

☐ Stomach or intestine surgery _____

☐ Brain tests (MRI, Cat scan, ultrasound)_____

☐ Brain wave tests (EEG) _____

☐ Had a seizure _____

☐ Had a fever _____

☐ Needed antibiotics _____

☐ Had feeding problems _____

☐ Had jaundice (yellow) _____ Needed lights _____

☐ Anemia _____ ☐ Needed transfusion _____

☐ Needed medicines _____

☐ Other _____

_____

DEVELOPMENTAL HISTORY

Please list your child's developmental steps as best as you can:

LANGUAGE	MOVEMENT	SELF CARE
Smiled _____ months	Held head up _____ months	Picked up small items _____ months
Turned to name _____ months	Rolled over _____ months	Eat with spoon _____ months
Waved _____ months	Sat alone _____ months	Took off shoes/socks _____ months
Point at items to show _____ months	Crawled _____ months	Take off clothes _____ months
Said Mama/Dada _____ months	Walked alone _____ months	Put on clothes _____ months
Understands directions _____ months	Walked up/down stairs holding rail _____ months	Toilet trained Urine _____ months Bowels _____ months
1st word besides mama/dada _____ months	Throws a ball _____ months	Washes hands _____ months
2 words together ("want milk" _____ months	Running _____ months	Brushes own teeth _____ months
Uses sentences _____ months/years	Jump forward _____ months	Cut with scissors _____ months

Please write 2 examples of the *MOST* complex speech your child has right now---i.e. for younger children, most complex words or phrases spoken; for older children, most complex sentences spoken. Please include examples of sentences with "but", "because" or "though" if he/she uses them:

_____

_____

_____

_____

INFANCY

Please indicate any concerns you had while your child was less than 1- year-old:

□ Colic _____ □ Cried a lot _____

□ Hard to calm down _____ □ Was sick a lot _____

□ Other _____

_____

HEALTH HISTORY

Please list any of your child's chronic or recurrent health problems:

Medical problem	Ages treated	Doctor who saw child
1.		
2.		
3.		
4.		
5.		

Please list any operations your child may have had, such as, ear tubes or having tonsils removed.

Operation	Ages treated	Doctor who operated
1.		
2.		
3.		
4.		

Please attach to this form a page that lists any additional medical issues or operations your child has had.

HEALTH HISTORY CONTINUED

Please list any medicines your child ***CURRENTLY*** is taking

Medicines & dose	When started	Prescribing doctor	Reason for taking
1.			
2.			
3.			
4.			
5.			

Please list any medicines your child has taken ***IN THE PAST*** for a chronic or recurring medical problem:

Medicines & dose	How long	Prescribing doctor	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please attach a list of additional medicines your child is taking or has taken before to this form.

SOCIAL INFORMATION:

Mother's/Stepmother's name: _____

Birthday_____

Address:_____ Phone:_____

Other phone:_____Email:_____

Last grade finished:_____ Occupation:_____

*Father's/Stepfather's name:*_____

Birthday_____

Address:_____ Phone:_____

Other phone:_____Email:_____

Last grade finished:_____ Occupation:_____

Other Legal Guardian(s):

Name:_____Birthday:_____

Address:_____Phone:_____

Other phone:_____Email:_____

Relation to child:_____

Last grade finished:_____ Occupation:_____

Name:_____Birthday:_____

Address:_____Phone:_____

Other phone:_____Email:_____

Relation to child:_____

Last grade finished:_____ Occupation:_____

Child is living with: (circle those that apply)

Both birth parents foster parents adoptive parents grandparents

Parent and step-parent one parent alone other relatives other

Please list other children living in the home:

Child's name	Birthday	Relation to child	Concerns
1.			
2.			
3.			
4.			
5.			
6.			

If more space is needed, please attach a list to this form

Are there family circumstances that have affected your child? *Please check all that apply:*

- ☐ Family moves
- ☐ Financial Difficulties
- ☐ Illness/disability of family member
- ☐ Death of a family member/friend
- ☐ Marital problems
- ☐ Other
- ☐ Separation Or Divorce
- ☐ Custody or visitation problems
- ☐ Family violence
- ☐ Neighborhood violence
- ☐ Problems w/ other children in the family

Does your child receive SSI/Disability? Y_____ N_____

Another form of aid?_____

FAMILY BACKGROUND

Please answer the following the best you can by showing which family member has had a certain issue.

	Mom	Dad	Brother	Sister	Grandma	Grandpa	Aunt	Uncle	Other
1. Speech delay									
2. Problems in math									
3. Problems in reading									
4. Slow learning									
5. Autism/PDD Asperger									
6. Cerebral palsy									
7. Seizures									
8. Depression									
9. Bipolar disorder									
10. Anxiety									
11. Schizophrenia/ Psychosis									
12. Trouble with drugs/alcohol									
13. Spent time in jail/ prison									
14. Genetic syndromes									

Please list any other family members with important issues below:

_____

_____

_____

_____

Please write any other concerns or information you would like me to know in the space provided below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Today's Date_____

Signature _____

Print name_____

Relation to child _____