DEVELOPMENTAL PEDIATRICS
Children's Hospital of The King's Daughters, Inc.
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NEW PATIENT COMPREHENSIVE HISTORY FORM

***Please** carefully read & complete **all** sections of this form.*

DEMOGRAPHICAL INFORMATION

Date :_______________ Person completing this form and relation to the child: ______________________________

Child's Name: ____
Last Name First Name Middle Initial

Birth date: ______________ Age: ____________ Sex: **O** Male **O** Female

Home Address: ____
Street City State Zip

Contact phone numbers: ______________ ______________ ______________
Home Work Cell/Mobile

Child's primary health care provider: ______________ Who recommended this evaluation? ______________

WHEN and WHY DID YOU FIRST BECOME CONCERNED ABOUT YOUR CHILD?

____
____
____
____

PLEASE STATE THE MAIN CONCERN(S) OR REASON(S) FOR SEEKING HELP AT THIS PARTICULAR TIME: (use back if needed)

____
____
____
____
____

WHAT SPECIFIC QUESTIONS WOULD YOU LIKE ANSWERED BY THIS EVALUATION?

1. ____
2. ____
3. ____

HAS YOUR CHILD EVER BEEN EVALUATED FOR THIS PROBLEM BEFORE? **O** Yes **O** No If yes, by whom and when?

____
____

PLEASE LIST NAMES OF OTHER PROFESSIONALS WHO HAVE EVALUATED YOUR CHILD and ANY DIAGNOISES PROVIDED:
(Examples: ENT, Neurologist, Psychiatrist (MD), Psychologist (PhD), LCSW, Counselor, Geneticist, Physiatrist (Physical Medicine & Rehabilitation), Developmental Pediatrician)

____
____

HOSPITALIZATIONS: O None O Yes *If yes, please provide date and reason for the hospitalization (s): ______________

____

SURGERIES: O None O Yes *If yes, please list approximate date and type of surgery: ______________

____

SERIOUS ACCIDENTS OR INJURIES: O None O Yes * If yes, please describe: ______________

____

PLEASE LIST ANY UNUSUAL AND/OR TRAUMATIC FAMILY EVENT IN YOUR CHILD'S LIFE WHICH YOU FEEL MAY HAVE AFFECTED YOUR CHILD (Examples: birth of sibling, death in the family, divorce, illnesses, frequent school changes, abuse)

EVENT	CHILD'S AGE	COMMENTS

PEER RELATIONSHIPS & SOCIAL SKILLS

Are there same age children in your neighborhood? **O** Yes **O** No
Does your child seek friendships with same age peers? **O** Yes **O** No
Is your child sought by peers for friendship? **O** Yes **O** No
Does your child have trouble making or keeping friends? **O** Yes **O** No *If yes, please explain*: ___

Who does your child prefer to play with? **O** Younger children **O** Older children O Same age children **O** Family members only **O** Alone/Solitary **O** Prefers adults

INTERESTS AND ACCOMPLISHMENTS OF YOUR CHILD

What are your child's favorite toys, games, hobbies, and interests? ___

Clubs, sports, recreational activities: ___

What are your child's areas of greatest accomplishment? ___

What does your child dislike doing most? ___

What do you like most about your child? ___

PAST MEDICAL HISTORY

BIRTH/NEWBORN HISTORY

1. Was the baby born on time (term gestation)? **O** Yes **O** No *Number of weeks born: early* ___ *late* ___
   - State reason (if known) for preterm or early birth: ___
2. Baby's birth weight: ___ Mother's age at the time of this pregnancy: ___
3. Number of pregnancies *prior to or before* the pregnancy with *this* child: ___
4. Number of children born prior to the pregnancy of *this* child: ___
5. List any complications or illnesses which occurred during this pregnancy: ___
6. List prescribed medications taken during this pregnancy: ___
7. List any over-the-counter medications taking during this pregnancy: ___
8. Did the mother drink any alcohol during this pregnancy? **O** No **O** Yes **O** Suspected **O** Not known
   - Number of drinks per day *and* in which trimesters: ___
9. Did the mother smoke cigarettes while pregnant? **O** No **O** Yes **O** Suspected **O** Not known Packs per day: ___
10. Did the mother take any illegal/street drugs used during the pregnancy? **O** No **O** Yes **O** Suspected **O** Not known
    - **O** Cocaine **O** Marijuana **O** Heroin **O** Other: ___
11. Type of delivery: **O** vaginal **O** cesarean section (C/S) **O** forceps **O** vacuum extraction **O** breech
12. Reason for delivery if not vaginal or repeat C/S: O fetal distress O premature rupture of membranes O high blood pressure (mother) O Pre-eclampsia O Breech presentation O Other: ___
13. Was resuscitation or oxygen required? **O** Yes **O** No. Apgar score (if known): ___ at 1 minute ___ at 5 minutes
14. Did the baby spend time in the special care nursery or NICU following birth? **O** No **O** Yes If yes, please explain: ___
15. Did your baby pass his/her newborn hearing screen prior to discharge from the hospital? **O** No **O** Yes
16. Infant's age when discharged from the nursery? ___

BEHAVIORS OF CONCERN:

****Please check any of the following which are concerning or unusual (**when compared to children of the same as your child)*

O Short attention span O Impulsive O Distractible O Restless, fidgety O Hyperactive O Poor concentration O Poor organization skills O Attention seeking O Incomplete task assignments	O Excessive anxiety/worry O Unusual fears or worries O Frequently sad O Depressed O Angry O Withdrawn O Shy O Low self-esteem O Bullied O Stranger anxiety O Social anxiety O Excessive irritability	O Unusual tantrums/meltdowns O Fighting O Aggressive behaviors O Defiance O Lying O Stealing O Fire setting O Destruction of property O Cruelty to animals O Bullies others O Unusual sexual activity O Frequent or abrupt mood swings O Hears or sees things others do not	O Difficulty falling asleep O Difficulty staying asleep O Sleep walking O Talking when asleep O Nightmares O Night terrors O Grinds teeth O Use of self stimulatory behaviors to calm or sleep (such as rocking, head banging)
Academic Concerns: O Reading O Spelling O Hand writing O Fine motor skills O Math O Verbal expression O Written expression	O Limited range of food preferences O Smells or sniffs foods/people/objects O Unusual sexual behavior O Separation anxiety (severe) O Obsessions	O Unusual eye contact O Lack of interest in playing with other children. O Unafraid of common dangers O No fear of strangers O Unusual Repetitive play or behavior O Lack of response to pain	O Rarely responds to name O Aloof/Indifferent O Resists change O Difficulty or meltdown with change in routines or with transitioning. O Unusual routines or rituals O Other:

THERAPIES (received/receiving) which are not related to early intervention or special education services:

O Occupational therapy O Physical therapy O Speech therapy Therapy Agency: ______________________________

EDUCATIONAL AND ACADEMIC INFORMATION

NAME OF CHILD'S SCHOOL:___________________________________City:_______________________Current Grade: ________

If applicable: # of years retained:______which grade(s)? ______ # years skipped:____which grade(s):___ Current reading level: ________

****COMPLETE THE NEXT SECTION ONLY IF YOUR CHILD WAS ENROLLED IN EARLY INTERVENTION OR SPECIAL EDUCATION*

OTHERWISE, GO ON TO THE NEXT PAGE (PAGE 3)

BIRTH TO 3 YEARS OF AGE:

EARLY INTERVENTION SERVICES

O Child received services but was discharged or transitioned/moved to special education program.

O Child is currently receiving early intervention services.

Specific therapies that the child received or is currently receiving: **O** Physical **O** Occupational **O** Speech **O** Other _______

SPECIAL EDUCATION SERVICES: (PAST AND/OR PRESENT)

O 504 Plan. What is the condition which qualifies child for 504 Plan?____

SPECIAL EDUCATION ELIGIBILITY CLASSIFICATION AS LISTED ON THE IEP:

O Developmentally Delayed (DD) **O** Cognitively Impaired *(Previously referred to as "Mentally Retarded")*

O Emotionally Disturbed (ED) **O** Speech/Language Impaired **O** Hearing impaired

O Autistic **O** Other health impaired (OHI) **O** Visually impaired

O Specific Learning Disability (SLD) ***In what area(s)____

INDICATE CLASSROOM SETTING ****ONLY IF CHILD IS IN SPECIAL EDUCATION***

O Preschool program **O** Full day or contained special classroom **O** Part day or resource **O** SECEP

THERAPIES RECEIVED/RECEIVING: **O** Occupational therapy **O** Physical therapy **O** Speech therapy **O** Other

CHILD'S TEMPERAMENT DURING THE FIRST MONTHS OF LIFE:

Difficult to calm or console?	O Yes O No	Enjoyed being held or consoled?	O Yes O No
Excessive irritability or fussiness?	O Yes O No	Difficulty developing predictable routine?	O Yes O No

DEVELOPMENTAL MILESTONES

******PLEASE INDICATE THE APPROXIMATE AGE WHEN YOUR CHILD WAS CONSISTANTLY ABLE TO DO THE FOLLOWING:***

GROSS MOTOR MILESTONES (indicate number of months or years)

Rolled over _____months **Sat supported** _____months **Crawled** _____months **Pulled to a stand** _____ months

Cruised (walked holding onto furniture)_____months **Walked independently** _____months **Ran well** _____months

Pedaled a tricycle _____months **Rode a 2 wheeled bike with training wheels** _____years

Rode a 2-wheeled bike without training wheels _____years

FINE MOTOR MILESTONES (indicate number of months or years)

Reached and grasped for small objects _____months **Transferred objects form one hand to another** ___months

Finger fed self _____months **Drank from a cup** (without a cover with minimal spilling) _____months

Fed self with spoon _____months **Undressed** _____years **Dressed** _____years **Potty trained** _____years

Age child showed definite hand preference _____years (My child is **O** left handed **O** right handed)

LANGUAGE MILESTONES (indicate number of months or years)

Smiled _____months **Cooed** (long vowel sound)____months **Laughed out loud** _____(months)

Razzed (blowing raspberries) _____months **Babbled** (ba-ba, ma-ma) _____months

Said "mama" (specifically for mother) _____months **Said "dada"** (specifically for father) _____months

Said first word (other than mama or dada) _____months **Consistently used two-word phrases** _____months

Consistently used pronouns correctly (I, me, he, she) _____months **Waved "bye-bye"** _____months

Played "patty cake" _____months **Followed one-step commands** _____months

Pointed to pictures in a book _____months **Knew 2 or more body parts** _____months **Stated full name** _____years

Stated age _____years **Stated address** _____years

SOCIAL MILESTONES (indicate number of months or years)

Follow *your* gaze or look in the direction in which you are looking _____months

Follow *your* point or look in the direction in which you pointed _____months

Point to *request* an object _____months

Bring you objects to *show or share with* you (not to request help such as opening a container) _____months

Point to show you something interesting (and look back to make sure you are doing this) _____months

Begin to engage in pretend play (ex: feeding a baby doll or making car sounds): _____years

ANY HISTORY OF LOSS OF DEVELOPMENTAL MILESTONES (***Skills which the child was consistently doing…not once or twice)
O No O Yes IF YES, PLEASE EXPLAIN: ____

____

____

WHAT IS THE FUNCTIONAL AGE OF YOUR CHILD (age your child acts the majority of the time) ________________

IF DIFFERENT THAN CHRONOLOGICAL AGE, PLEASE EXPLAIN: ______________________________

____

WHO LIVES IN THE HOME WITH THE CHILD? ______________________________

PARENT MARITAL STATUS: O Single O Married O Separated O Divorced O Never married

Are both parents are involved in life of this child? O Yes O No. If No: child rarely see O Father O Mother

PARENT INFORMATION (**Please include information for biological parents)

	FATHER	MOTHER
FULL NAME:		
ADDRESS: (If does not live with child)		
CURRENT AGE:		
OCCUPATION:		
HIGHEST GRADE COMPLETED:		
EARLY SCHOOL LEARNING PROBLEMS?		
BEHAVIOR OR PSYCHIATRIC ISSUES?		
SOCIAL OR LEGAL PROBLEMS?		

SIBLINGS: (BROTHERS OR SISTERS) *USE BACK IF NEEDED

NAME	SEX	AGE	GRADE	SPEECH/LANGUAGE/SCHOOL ISSUES:	FULL OR HALF SIBLING?
1.					☐ Full ☐ Half Share: ☐ Mother ☐ Father
2.					☐ Full Half Share: ☐ Mother Father
3.					☐ Full Half Share: ☐ Mother Father
4.					☐ Full ☐ Half Share: ☐ Mother ☐ Father
5.					☐ Full Half Share: ☐ Mother Father

YOU ARE DONE WITH THE PARENT PORTION OF THIS FORM

OFFICE USE ONLY: **O I have reviewed and/or added to the above comprehensive history.** **O Dictated: JOB #**______________

______________________________ ______________________
Date

Family History

Please identify family medical history.

Illness	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Deceased								
- Deceased Cause								
ADHD								
Aggressiveness								
Alcohol Abuse								
Antisocial Behavior (assaults, thefts, arrest, jail)								
Anxiety disorder								
Asperger disorder								
Autism								
Bipolar Disorder								
Blindness								
Conduct disorder								
Congenital Deafness								
Cognitive Challenged/Impaired (Cognitive Impairment)								
Depression								
Hearing Impairment								
Inherited Disorders or Abnormalities (Genetic Disorder)								
Learning Disabilities (math, writing, etc.)								
Manic Depressive Disorder								
Intellectual Disability								
Oppositional Behavior as a child/adult (Oppositional Disorder of Childhood)								
Oppositional Defiant Disorder (ODD)								
Pervasive Developmental Disorder (PDD)								
Physical Abuse								
Psychosis								
Reading Disability (Dyslexia)								
Schizophrenia								
Sexual Abuse								
Substance Abuse (marijuana, crack, cocaine)								
Tic Disorder								
Unusual Mood Swings (Mood Swings)								
Visually Impaired (Impaired Vision)								