Children's National Medical Center®

NEURODEVELOPMENTAL PEDIATRICS

(For use of Children's National Medical Center only)

Patient name: _____

Date of Birth: _____

Medical Record #: _____

Encounter (Acct.) #: _____

HISTORY FORM (AGES 5 – 18 YEARS)

Please complete this form prior to your child's first visit. It will be very helpful if you can bring with you copies of reports from any evaluations your child has had: physical therapy, occupational therapy, speech and language therapy, early intervention services, etc. If your child has an IEP or 504 plan, please bring that as well.

Child's Name _____

Age _____ years _____ months Today's Date _____

Child's Parent/Caregiver(s) _____
Person Completing Questionnaire _____

Please list your questions or concerns _____
_____
_____

When did you first become concerned? _____

What first caused you to become concerned? _____
_____
_____
_____

PAST MEDICAL HISTORY

Child's birth weight_____

How long was the pregnancy with your child?
_____ Full term (Born within 2 weeks of date due)
_____ Born premature at _____ weeks

- Did you/ the child's mother have high blood pressure, diabetes, infections or any other pregnancy complications?
  Please describe briefly _____
  _____
- Did you/the child's mother smoke *any* cigarettes during the pregnancy?_____
- Did you/the child's mother drink *any* alcohol during the pregnancy?_____
- Did you/the child's mother take any medications? (antidepressents, asthma medications, etc)
  _____
- Did you/the child's mother use any illegal drugs? (marijuana, barbituates, cocaine, etc).
  _____

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Was your baby's delivery
_____ a normal vaginal delivery
_____ assisted with forceps or vacuum
_____ C-section. Why? _____

How long was your child in the hospital after delivery? _____

Was your child in the NICU (Neonatal Intensive Care Unit) Yes _____ No? _____

Please describe any other problems your child had during the newborn period _____
_____
_____

Has your child been diagnosed with a genetic disorder? (Down's syndrome, Fragile X, etc)
_____
_____

Has your child ever been hospitalized?
_____
_____

Has your child ever had surgery?
_____
_____

Has your child ever had any medical problems? (including frequent ear infections, asthma, etc)
_____
_____

Has your child ever had problems with feeding, or difficulty gaining weight?
_____
_____

Does your child have any allergies?_____

Has your child's vision been checked? _____

Has your child's hearing been checked? _____

Are your child's immunizations up to date? _____

Is there anything else we should know about your child's health? _____
_____

Have any of the following tests been performed? (Check and bring results to visit):

Blood Tests	_____ Ammonia	_____ Lactate	_____ Pyruvate
	_____ Lead Level	_____ Thyroid Function	_____ Serum Amino Acids
Urine Tests:	_____ Metabolic Screen	_____ Organic Acids	_____ Amino Acids

Magnetic Resonance Imaging (MRI) of the brain: _____
Electroencephalogram (EEG): _____
Brainstem Auditory Evoked Potential (BAER): _____
Cortical Auditory Evoked Potential (CAER): _____
Echocardiogram (ECHO): _____
Any other testing not listed here: _____

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REVIEW OF SYSTEMS

Has your child ever lost any skills that he or she previously had (that is gained a developmental milestone then completely lost that ability)? Yes __ No _____ If yes, please give details:

_____
_____
_____
_____
_____

Has your child ever had a seizure? _____
_____

Has your child ever had staring spells when you had difficulty getting his/her attention? _____
Please detail _____
_____

Has your child ever had/does your child have a motor tic (a sudden contraction of a muscle group, a flinch) or vocal tic (involuntary repetitive sound)? _____
_____
_____
_____

Does your child have a good appetite and eat a variety of foods? _____

Does your child sleep well? Yes _____ No _____
Usual bedtime: _____
Usual wake time: _____
Nap(s): _____

DEVELOPMENTAL HISTORY

Please answer all applicable items. Remember, not all children develop at the same rate.
How old was your child when he/she first:

	Actual Age	or	Approximate Age	Relative to Siblings Slower	Faster	Same
GROSS MOTOR						
Sat up on own	_____		_____ < 9 mos.	<_____	_____	
Crawled (how/type)	_____		_____ <10 mos.	<_____	_____	
Stood Alone	_____		_____ <13 mos.	<_____	_____	
Walked Alone	_____		_____ <16 mos.	<_____	_____	
Ran	_____		_____ <18 mos.	<_____	_____	

Relative to Siblings

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LANGUAGE/SOCIAL	Actual Age	or	Approximate Age		Slower	Faster	Same
Smiled	_____		_____ < 2 mos	<_____			
Cooed	_____		_____ < 2-3 mos	<_____			
Babbled	_____		_____ < 4-6 mos	<_____			
Said first words	_____		_____ < 7 mos.	<_____			
Understandable single words	_____		_____ < 9 mos	<_____			
Spoke in two word phrase	_____		_____ < 2 yrs.	<_____			
Spoke in full sentences	_____		_____ < 3 yrs.	<_____			

Does your child have any articulation problems (problems speaking clearly)? _____
_____

FINE MOTOR	Actual Age	or	Approximate Age		Relative to Siblings Slower	Faster	Same
Dress self (pull on clothes)	_____		_____ < 4 yrs.<	_____			
Buttoned buttons	_____		_____ < 5 yrs.<	_____			
Tied Shoe laces	_____		_____ < 5 yrs.<	_____			

Can your child write letters/numbers? Yes _____ No _____
With the Right hand _____ Left hand _____ or Both hands _____
Can your child read words? Yes _____ No _____

At what age was your child toilet trained for bladder? _____ for bowel?_____
Please briefly describe any problems with toilet training: _____
_____

BEHAVIORAL HISTORY

How old does your child act?

What are your child's greatest strengths?

What are your child's main (favorite) play interests?

Does your child have any behavioral problems in school?

Does your child have any behavioral problems at home?

Do you feel your child's interactions with other children are typical for his/her age?

Does your child have problems separating from parent(s)?

Does your child have any major fears or worries?

Does your child have any repetitive behaviors (i.e., hand flapping, head banging, rocking, walking in circles)?

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Does your child have any ritualistic behaviors (i.e., needs objects in certain place before going to bed, has to go the same route every time)? Please describe briefly:

_____

_____

Is your child bothered by any things (stimuli) that do not seem to bother other people or yourself (i.e., sounds like a garbage truck passing, bright lights, certain clothing or the labels on pants and shirts, being touched, certain texture of food)? Please describe briefly:

_____

_____

Is your child aggressive toward others?

Does your child ever do things to injure himself/herself?

Do you or others feel that your child

_____is hyperactive? _____

_____is in constant motion? _____

_____is fidgety? _____

_____is overactive? _____

_____is impulsive? _____

_____is easily distracted? _____

_____has problems focusing on things for long period? _____

If yes, on what can he/she focus (e.g., cartoons, video games, computer…)? _____

_____

_____is disorganized? _____

_____is moody? _____

EDUCATION/COGNITIVE HISTORY

Where does your child attend school?_____

How long has he/she been attending? _____

Is your child involved in any other organized activities or sports?

Was your child evaluated by the Infant/Toddler Program or Child Find? Yes _____ No _____

Does you child have either of the following:

_____ Individualized Education Plan (I.E.P.)

_____ Section 504 Plan

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Has your child had any of the following (indicate date, name of agency or school, and check type):

_____ Pediatric Developmental evaluation _____
_____ Psychological evaluation _____
_____ Speech and Language evaluation _____
_____ OT or PT assessment _____
_____ Other _____

If your child is not receiving special educational assistance, please skip the next two questions.

Does your child have an educational disability, according to the school? What is it? _____

_____

What are the special or related services, if any, your child is receiving? (Please state what the service is and the number of hours)
School Services _____

_____

Private Services _____

_____

FAMILY/SOCIAL HISTORY

Family Education History (Please complete all information known even if the child does not reside with biological parents):

Name	Age	Highest Grade Completed in School	Occupation
Mother			
Father			
Siblings			

Who in the family does your child resemble most? _____

_____

Please complete the following chart on the next page. If there is anything else we should know about your child, please use this space and the space on the back of the last page.

_____

_____

_____

_____

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Child's Relatives

Please indicate which of the following conditions were or are present in your child's immediate biological relatives, as best you can. Check the box corresponding with the relative(s) possessing the disorder listed on the left.

	Mother	Father	Sister(s) How many?	Brother(s) How many?	Grandparents Which?	Aunts/Uncles Which?
Hearing Problems						
Speech Problems						
Developmental Delay						
Slowness in talking						
Slowness in walking						
Bedwetting after 5 yrs.						
Mental Retardation						
Hyperactivity						
Attention Problems						
Tics						
Learning Problems						
Trouble Reading						
Trouble with Math						
Autism/Asperger Syndrome						
Depression						
Mania						
Schizophrenia						
Other Emotional Problem (specify)						
Sleep Problems (specify)						
Birth Defects						
Thyroid problems						
Kidney Disease						
Heart Disease						
High Blood Pressure						
Sudden Death Under Age 50						
Vision Problems						
Seizures						
Cerebral Palsy						
Arthritis						
Lupus						
Cancer						

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