Developmental Pediatrics
Boston Children's Health Physicians
Until every child is well™

Phone: 914-304-5250
Fax: 914-345-1752

Dear Parent/Guardian:

Please answer the following questions as best as you can, and bring this form in with you on the day of your appointment. If you have any questions about a specific item of information being asked, you can call before your appointment as the information will be covered during the appointment.

If you have a young child, please bring some favorite toys to play with.

Thank You.

Name of Child: _____ **Date of Birth:** _____

Are you concerned about how your child:

☐ **behaves** ☐ **develops** ☐ **learns** ☐ **uses language** ☐ **pays attention**

MEDICATIONS

Currently takes: _____

Taken in the past: _____

ALLERGIES

Does your child have known allergies to food or medication? ☐ Yes ☐ No

BIRTH HISTORY

Child's weight at birth: _____ lbs. _____ oz.

Was your child born full term? ☐ Yes ☐ No If not, at what week of gestation? _____ weeks

What type of delivery did you have?

☐ Vaginal delivery: ☐ normal/spontaneous ☐ Pitocin-induced

☐ Cesarean Section: If so, was this due to ☐ repeat ☐ fetal distress

How old was the mother at the time of delivery? _____ years

What number pregnancy was this (for example 1st, 2nd, etc.)? _____

What number delivery was this (for example 1st, 2nd, etc.)? _____

Were there any maternal medical problems during the pregnancy? ☐ Yes ☐ No

If yes, what was/ were the problem(s)? _____

_____

Were there any medications taken during the pregnancy? ☐ Yes ☐ No

If yes, what medication(s) and why? _____

_____

Was your child in the NICU? ☐ Yes ☐ No

If yes, for how long and why? _____

_____

FAMILY & SOCIAL HISTORY

Family Composition

Who lives at home? _____

Mother's highest grade completed __ Occupation _____

Father's highest grade completed __ Occupation _____

Please list all other brothers and sisters of child:

Name	Age	Gender
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

Do any other members of the family have problems with attention, behavior, learning, using language, have developmental disabilities including autism, or died from a heart condition prior to the age of 50? ☐ Yes ☐ No

If yes, please explain: _____

_____

SLEEP HISTORY

Child usually goes to sleep at _____PM

Does your child fall asleep independently? ☐ Yes ☐ No

How long does it take to fall asleep? _____

Does your child sleep through the night? ☐ Yes ☐ No

Child ☐ gets up ☐ is wakened at _____AM

Does your child snore – 2 or more times a week? ☐ Yes ☐ No

Does your child maintain a stable bedtime and wake time seven days a week? ☐ Yes ☐ No

MEDICAL HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any/all operations, hospitalizations (including Emergency Room visits), and procedures your child has had:

Where	When	Why

When was your child's last vision screening or evaluation? _____ ☐ Normal ☐ Other _____

hearing screening or evaluation? _____ ☐ Normal ☐ Other _____

Did/does your child have frequent ear infections? ☐ Yes ☐ No

Does your child have

Poor growth?	☐ Yes	☐ No
Heart problem?	☐ Yes	☐ No
Asthma or other respiratory problems?	☐ Yes	☐ No
Stomach or bowel problems?	☐ Yes	☐ No
Urine problems?	☐ Yes	☐ No
Motor weakness or coordination problems?	☐ Yes	☐ No
Headaches?	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No
Anemia or other blood disease?	☐ Yes	☐ No

If you answered 'Yes' to any of questions above, or if your child has any other health care problem/s that are not listed, please explain:

_____

_____

_____

DEVELOPMENTAL HISTORY

Please list age at which your child:

Sat up	_____	Walked alone	_____
Said 'Mama' & 'Dada'	_____	Spoke in single words	_____
Spoke in 2-word phrases	_____	Spoke in few-word phrases	_____
Speech understood by strangers	_____		

School & Services

Name of School _____ District _____

Are any of the following therapies being currently provided?

☐ Physical Therapy ☐ Speech Therapy

☐ Occupational Therapy ☐ Resource Room

☐ Counseling ☐ Other: _____

Has your child ever had any evaluations such as audiology, psychology, or speech/language?

PLEASE BRING A **PHOTOCOPY** OF EACH EVALUATION WHICH YOU WILL LEAVE IN THE OFFICE. Our office staff will not be able to make copies for you.

Describe peer interactions (interactions with same age children who are not siblings):

_____

_____

_____

*For children **4** years and older:*
Would you say that your child displays the following behaviors?

1.	Is “on the go” or “driven by a motor”	☐ Yes ☐ No
2.	Has difficulty engaging in quiet activities	☐ Yes ☐ No
3.	Fidgets or squirms	☐ Yes ☐ No
4.	Has difficulty staying seated	☐ Yes ☐ No
5.	Restlessness	☐ Yes ☐ No
6.	Runs about and excessively and inappropriately	☐ Yes ☐ No
7.	Talks excessively	☐ Yes ☐ No
8.	Blurts out answers before questions completed	☐ Yes ☐ No
9.	Has difficulty awaiting his or her turn	☐ Yes ☐ No
10.	Interrupts or intrudes on others	☐ Yes ☐ No
11.	Avoids tasks which require sustained mental effort	☐ Yes ☐ No
12.	Has difficulty organizing tasks and activities	☐ Yes ☐ No
13.	Has difficulty sustaining attention	☐ Yes ☐ No
14.	Does not seem to listen	☐ Yes ☐ No
15.	Is easily distracted	☐ Yes ☐ No
16.	Is forgetful in daily activities	☐ Yes ☐ No
17.	Loses necessary items such as school books and materials	☐ Yes ☐ No
18.	Has difficulty following through on instructions from others	☐ Yes ☐ No