HEARTLIGHT HEALING ARTS

DEVELOPMENTAL PEDIATRICS HISTORY FORM

IDENTIFYING INFORMATION:

Child's Name:_____ Date of birth:_____

Date form completed:_____ Referred by:_____

Parents' names: _____
Address:_____

Phone number: (home)_____Cell #_____

Cell #_____Work#_____

REASON FOR REFERRAL:

What are you hoping to learn from this evaluation? (Main questions, concerns, etc.)

_____

_____

_____

_____

What diagnoses does your child have?

Autism _____
ADHD _____
Anxiety _____
Depression _____
Learning Disability _____
Sensory integration or sensory processing disorder _____
Language delay _____
Verbal apraxia _____
Other _____

PREGNANCY/BIRTH HISTORY:

Pregnancy: Full-term? _____

Premature? _____ If yes, how many weeks gestation? _____

Birth weight _____ Apgar scores _____

Type of delivery: Vaginal _____
Cesarean Section _____ Why? _____

Any complications during pregnancy? (bleeding, high blood pressure, infections, diabetes, etc.)

_____

Amniocentesis during pregnancy? _____ Results/concerns: _____

Ultrasounds during pregnancy? _____ Results/concerns: _____

During pregnancy, was mother given:
Rhogam?_____(shot for Rh negative blood type)
Flu Shot?_____

Did mother:
Eat a lot of tuna?_____ Salmon?_____
Have dental work involving mercury fillings?_____

Weight gain during pregnancy: _____

Any medications taken during pregnancy? _____

Cigarette smoking or alcohol intake during pregnancy? _____

During pregnancy, was your child unusually active? _____ Under-active? _____

Any problems after delivery?

Jaundice _____ If yes, phototherapy? ____
Respiratory problems _____
Need for oxygen? _____ Ventilator? _____ If yes, for how long? _____
Infections _____
Poor feeding _____
Other _____

PREGNANCY/BIRTH HISTORY (CONTINUED)

Any problems in early infancy? Unusually quiet ____ Unusually active _____ Colic ____
Unusually stiff or floppy _____ Feeding problems _____
Reflux _____ Constipation _____

Breast-fed or formula fed? _____ Type of formula? _____

MEDICAL HISTORY:

Primary care physician:_____

Office phone number:_____Fax #_____

Address_____

When was your child's last routine physical examination? _____
Were any problems identified? _____

Are your child's immunizations up-to-date? _____
Any adverse reactions? _____ If yes, describe _____

Has your child had:

Hearing screening or audiology evaluation? _____
If yes, date and results? _____
Vision screening or ophthalmology evaluation ? _____
If yes, date and results? _____

Are you concerned about your child's hearing or vision? _____

Has your child had any medical evaluation for the cause of his/her behavioral, developmental, or medical symptoms?

Blood tests (e.g., lead, thyroid, etc.)
_____

Genetic testing _____

EEG _____

Brain MRI _____

Other _____

Please bring copies of blood and urine tests and copies of reports from any medical evaluations (e.g., by genetics, neurology, GI, etc.,) if available. We do not need to see actual EEG or MRIs.

MEDICAL HISTORY (CONTINUED)

Any history of: Serious illnesses? _____

Serious injuries? _____

Surgeries? _____

Hospitalizations? _____

Is your child currently on any routine medication? If so, please list below along with name of prescribing physician:

_____

_____

Please indicate whether your child now has, or has had in the past, any of the following. (Please indicate at what ages these areas were problematic.)

_____ Ear infections_____

_____ Frequent illnesses_____

_____ Frequent need for antibiotics_____

_____ Unusual response to illness (e.g., unusual lethargy or vomiting out of proportion to the illness?)

_____ Unusual odors to urine or sweat

_____ Diarrhea _____

_____ Constipation _____

_____ Gas/Belching/Reflux

_____ Stomach aches

_____ Seeking pressure to abdomen

_____ Nausea/Vomiting

_____ Headaches

_____ Allergies to: _____Environment (e.g., pollen, dust) _____

_____Foods _____

_____Medications _____

_____ Eczema/dry skin

MEDICAL HISTORY (CONTINUED)

_____ Birthmarks

_____ Cracking or peeling nails

_____ Asthma

_____ Snoring (If yes, any apnea or gasping for air? _____)

_____ Red cheeks or red ears (without obvious reason)

_____ Sweating at night

_____ Intolerance to cold or heat

_____ Abnormal weight gain or loss _____

_____ Seizures _____

_____ Tics/Eye twitching or blinking _____

_____ Excessive fatigue or poor endurance

_____ Excessive thirst

Are any medical specialists currently involved in your child's care (e.g., allergist, neurologist, etc.)? If yes, please list their names, specialties, and phone numbers.

_____

_____

DIET HISTORY:

Does your child have a good appetite?_____

Is he/she a picky eater?_____ If yes, at what age did picky eating start? _____

Does your child have any unusual food preferences or dislikes? Any food cravings?

_____

Do any foods seem to make your child's behavior better or worse? _____

_____

DIET HISTORY (CONTINUED)

Have you tried any specific types of diets to see if they affected your child's behavior or development (e.g., casein-free, gluten-free, etc.)? If so, when were they done and were they helpful?

_____

Is your child currently taking any vitamins or other nutritional supplements? If so, please list names of supplements and doses.

_____

_____

_____

_____

Does your child eat a lot of: Dairy products? (Milk, cheese, yogurt, etc.): _____

Please list daily amounts of:

Milk _____

Cheese _____

Yogurt _____

Ice cream _____

Carbohydrates or wheat-containing products? (Bread, pasta, cereal, cakes, cookies, etc.)

_____

What is a typical meal for your child:

At breakfast? _____

At lunch? _____

At dinner? _____

DIET HISTORY (CONTINUED)

What types of the following foods does your child eat?

Protein (e.g., meat, eggs, peanut butter)_____

Fruit_____

Vegetables_____

DEVELOPMENTAL HISTORY:

Are you concerned about your child's development? _____
If yes, at what age did you first become concerned? _____
What concerned you initially? _____

What age do you think your child acts like, in terms of development and learning? _____

What are your main concerns about your child's development? _____

_____

_____

_____

What are your child's main developmental strengths? _____

_____

_____

_____

Has your child lost previously attained skills? _____
If yes, at what age did the loss begin? _____
What skills were lost? _____

Was there any event, illness, etc. that appeared to coincide with the loss of skills?_____

_____

DEVELOPMENTAL HISTORY (CONTINUED)

Has your child had any previous evaluations of his/her development or learning? _____

If yes, please indicate the type of evaluation, date, and general results. (Please bring any reports of previous evaluations or testing with you to your first appointment for us to keep. If your child has had numerous evaluations, please bring copies of the most recent. If possible, bring originals of older evaluations for review; can then determine whether copies would be helpful.)
_____

_____

Please indicate the age at which your child achieved the following skills: (Do not worry if you cannot remember any or all of these milestones; their importance can be determined during our discussion at the first appointment.)

Language skills:

Social smile (smiled in response to you) _____
Laughed _____
Babbled _____
Said "mama", "dada"_____
Understood "no" _____
Pointed to communicate _____
Said first word _____
Spoke in jargon ("gibberish") _____
Waved bye-bye _____
Played "peek-a-boo"or "pat-a-cake" _____
Followed a one-step instruction _____
Pointed to pictures _____
Identified body parts _____
Combined two-words _____
Had a 50-word vocabulary _____
Spoke in short (at least three-word) sentences _____
Used pronouns (e.g., I, me, you) correctly _____
Able to state full name_____
Able to state age _____
Identified basic colors _____

If your child is non-verbal or has very limited language:
-How does he/she communicate with you? (E.g., lead you to desired objects/food/activities, point, etc.) _____
-Does your child respond to his/her name? _____
-Is he/she able to indicate yes/no (e.g., with words or by head nod/shake)?_____

DEVELOPMENTAL HISTORY (CONTINUED)

Language skills (continued)

Did your child have an early or unusual interest in letters or numbers?_____

Is your child unusually literal? (Ex: Doesn't understand idioms – such as "It's raining cats and dogs" or "I've got a frog in my throat." _____

Does he/she have difficulty with conversations?_____

Does he/she repeat memorized words/phrases from books, videos?_____
Any problems with articulation (clarity of speech)? _____

Has your child been diagnosed with verbal apraxia or dyspraxia? _____

If yes, is he/she getting a type of speech therapy known as PROMPT therapy?_____

Does your child use any type of augmentative communication (such as sign language, PCS or picture symbols, computer device?)_____

If under age 3 (or if you have concerns in this area), estimated vocabulary size? _____

Does your child have trouble understanding what is asked of him/her? _____

Does he/she seem to have difficulty processing information quickly? _____

Does he/she have difficulty expressing himself/herself? _____

Does he/she have difficulty following multi-step directions? _____

Are any languages other than English spoken in the home? _____

Gross motor skills:

Rolled over _____ Sat alone_____
Crawled _____
Pulled to standing _____
Cruised around furniture_____
Walked independently_____
Walked up steps_____
Pedaled tricycle_____

DEVELOPMENTAL HISTORY (CONTINUED)

Gross motor skills (continued)

Rode bicycle: With training wheels _____ Without training wheels _____
Skipped _____
Currently coordinated? _____ Clumsy? _____ Average? _____

Have you been told your child has:
_____ Hypotonia or low tone?

_____ Motor planning problems?

Fine motor/Adaptive skills:

Right-handed or left-handed? _____
Picked up small objects with a pincer (thumb-forefinger) grasp_____
Scribbled with a crayon _____
Fed self with fingers_____
Used spoon _____
Used fork_____
Drank from a cup_____
Toilet-trained _____
Dry at night _____
Undressed completely _____
Dressed self completely _____
Unbutton/button_____
Zippers_____
Tied shoes_____
Able to put shoes on correct feet_____
Handwriting: Legible?_____
Trouble with spacing and sizing of letters?_____
Trouble planning on the page(e.g., runs out of room)?_____

BEHAVIORAL HISTORY:

Are you concerned about your child's behavior? _____

If yes, what are your main concerns about your child's behavior?_____

_____

_____

BEHAVIORAL HISTORY (CONTINUED)

What are your child's behavioral strengths? _____

_____

_____

Has you child ever had any evaluations of his/her behavior? _____
If yes, please indicate type of evaluation, date and general results. (Please bring reports of any previous evaluations to your first appointment for us to keep.)

_____

_____

Has your child ever received any formal interventions regarding his/her behavioral difficulties (such as counseling/therapy, medication, etc.)? ____ Is he/she currently receiving therapy? _____

_____

_____

Is your child currently on any medications for behavior? If yes, please list medications, doses, and name of prescribing physician.

_____

Please indicate whether your child has difficulties in any of the following areas:

Hyperactivity
Inattention
Impulsivity
Distractibility
Significant variability in behavior from day to day
Temper tantrums
Oppositional behavior
Aggressiveness
Destructiveness
Lying
Stealing
Self-injurious behaviors
Bed wetting
Difficulty getting along with siblings or peers
Trouble making friends

BEHAVIORAL HISTORY (CONTINUED)

Depressed mood
Mood swings
Low self-esteem
Anxiety/Nervousness
Nail biting
Thumb sucking
Obsessions
Compulsions
Sleep problems
Withdrawn behavior
Preference to play alone
Poor eye contact
Lack of make-believe play
Trouble with transitions
Unusual sensitivities (e.g., to sounds, being touched, tags on clothing)

EDUCATIONAL HISTORY:

Do you have any concerns about your child's learning or school placement? _____

_____

_____

Current school: _____

Grade: _____ Estimated number of children in classroom _____

Type of classroom (Regular education, special education) _____

Has your child ever repeated a grade? _____

EDUCATIONAL HISTORY (CONTINUED):

Has your child had any formal testing regarding his/her learning (such as psychological testing, educational testing, speech/language evaluation)? If yes, please bring reports of previous testing or evaluations to the first appointment for us to keep.

_____

_____

_____

Is your child receiving any special services at school or outside of school (such as speech-language therapy, occupational therapy, tutoring, etc.)? If yes, please list type of therapy, where received, and the frequency of therapy.

Speech therapy_____

Occupational therapy_____

ABA/VB_____

Floor Time_____

Relationship Development Intervention (RDI)_____

Other_____

What are your child's: Best subjects in school?_____

Most difficult subjects?_____

How do you think your child learns best? Visual learner _____
Auditory learner _____
"Hands on" learner _____

FAMILY/SOCIAL HISTORY:

Please indicate whether the following illnesses/disorders are present in your family's history and who has/had them:

Attention Deficit Hyperactivity Disorder _____
Learning Disability_____
Mental Retardation_____
Autism/Pervasive Developmental Disorder_____
Language Delay_____
Articulation Problems_____
Fragile X Syndrome_____
Hearing Impairment_____
Vision Impairment _____
Seizures_____
High Blood Pressure_____
Heart Disease (including abnormal heart rhythms, sudden death)_____
Thyroid Disease_____
Allergies _____
Asthma _____
Food Intolerances_____
Liver Disease_____
Gastrointestinal Problems (Inflammatory bowel disease, celiac disease, irritable bowel syndrome, etc.)_____
Night blindness/Trouble seeing at night _____
Diabetes _____
Arthritis _____
Autoimmune disorders (lupus, rheumatoid arthritis)_____
Tics/Tourette's Syndrome _____
Depression _____
Anxiety_____
Obsessive-Compulsive Disorder_____
Bipolar Disorder (Manic-Depressive Illness) _____
Schizophrenia_____
Other_____

FAMILY/SOCIAL HISTORY (CONTINUED)

Who currently lives in the household? _____

Are parents: Married? _____ Separated? _____ Divorced? _____ Other ____

Father's occupation: _____

Mother's occupation:_____

Names and ages of siblings, and any behavioral or developmental concerns:

_____

_____

_____

Any recent social stressors (e.g., deaths/losses, moves, change in family situation)?

_____

_____

_____