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 __________________

If not on dairy products, any milk substitutes (e.g., rice/almond/coconut milk)? ____________

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____________________
Intellectual Disability____________________
Autism Spectrum 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 ____

Occupation (Mother/Spouse/Partner): ____

Occupation (Father/Spouse/Partner): ____

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

____

____

____

____

____

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

____

____

____