Developmental Pediatric Service
Patient Information Form

How well do you speak English? ☐Very Well ☐Well ☐ Not well ☐Not at all

Patient Information

Patient First & Last Name:	Date of Birth	☐ Male ☐ Female
Street Address	City	State/Zip
Race:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latina ☐ Unknown/Not Reported	

Parent's Information

Legal Guardian's Name if other then parent:		
Mother's First & Last Name:	Date of Birth	Martial Status:
Street Address	City	State/Zip
Primary Phone Number	Secondary Phone Number	SS#:
Employer Name	Employer Address	Employer Phone Number
Father's First & Last Name:	Date of Birth	Martial Status:
Street Address	City	State/Zip
Primary Phone Number	Secondary Phone Number	SS#:
Employer Name	Employer Address	Employer Phone Number

Pediatrician/Referral Information:

Pediatrician's Name	Phone Number	Who Referred You?
Reason for the Referral:		

Insurance Information:

Primary Insurance Name	Subscriber First & Last name	Date of Birth
Group Number	ID#	Phone Number
Address	City	State/Zip
Secondary Insurance Name	Subscriber First & Last name	Date of Birth
Group Number	ID#	Phone Number
Address	City	State/Zip

Child's Name ______________________________________ **Date of Birth**_______________

Date Form Completed ____

PLEASE TELL US YOUR REASON FOR THIS VISIT:

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WHEN DID YOU FIRST BECOME CONCERNED? ____________________________________

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HAVE YOU SEEN ANY OTHER SPECIALISTS FOR THIS CONCERN? _________________________

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HAS YOUR CHILD HAD ANY SPECIAL EVALUATIONS OR TESTING DONE? IF SO, PLEASE LIST TYPE OF TESTING OR SPECIALIST, AND WHEN AND WHERE EVALUATION WAS DONE. ALSO LIST ANY THERAPIES (PHYSICAL, SPEECH, OCCUPATIONAL, EMOTIONAL, OR BEHAVIORAL AND WHEN/WHERE).

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The information obtained from the following checklists will assist us in our evaluations of your child. Please try to answer all the questions, even though some of the answers may be difficult to remember. Place an "X" in the appropriate column following each item. Please feel free to add extra information in the spaces provided.

Pregnancy	**True**	**Not True**	**Other Information**
Had previous pregnancy (pregnancies)			(how many?)
Had previous miscarriage(s)			(how many?)
Had problems getting pregnant			
Was unplanned pregnancy			
Bleeding during pregnancy			
Vomited frequently			
Had high blood sugar/diabetes			(how controlled?)
Had toxemia (high blood pressure)			
Had illnesses requiring hospitalization			(what illness?)
Had fever			
Lost weight			
Needed bedrest			
Had any accidents			
Was stressful time			
Smoked cigarettes			(how many)
Drank any alcohol			(how much)
Took drugs /Rx medications			(What kind and how much?)
Labor lasted more than 12 hrs			
Difficult delivery			
Forceps/Vacuum delivery			
Delivery by C-Section			
Breech delivery			
Other Problem			
Premature? (< 37 weeks)			(how many weeks)

Please tell us what hospital your baby was born in: ___________________________________

What City and State: _______________,_____ **Birth weight:**__________________

NEWBORN PERIOD

Place an "X" in the column appropriate for each item. Please try to answer each question.

	True	Not True	Other information
Baby went home from hospital with mother			
Was sick at birth			
Needed ventilator			
Needed oxygen			
Had an infection(s)			
Had trouble feeding			
Needed special formula			
Required surgery			
Was jittery			
Had convulsions (seizures)			
Was given medication(s)			
Needed phototherapy for jaundice			
Other			
Other			

Any problems during the first month at home:____

____

____

____

HAS YOUR CHILD EVER HAD?

Health	Yes	No	Ages	Details
Hospitalizations				
Operations/Surgeries				
Injuries				
Seizures				
Ear Infections				
Pneumonia				
Asthma				
Fevers with viruses				
Recurrent infections				
Reactions to shots				
Skin problems				
Anemia				
Trouble eating				
Special diets				
Slow weight gain				
Medications for other than infection				
Trouble seeing				
Trouble hearing				

Other problems:____

____

PLEASE CIRCLE ALL SYMPTOMS THAT YOUR CHILD HAS **AT THIS TIME**.

SYSTEM
General- Weight, growth changes, fever, weakness, fatigue

Skin- Rash, Dryness, turning blue, jaundice, changes in skin, hair, nails

Head- Headaches

Eyes- Corrective lenses, vision, redness, glaucoma, cataracts, double vision, pain, tearing, injury, crossed eyes

Ears- Hearing, discharge, pain, dizziness, ringing ears, infections

Nose- Colds, nose bleeds, runny nose, sinus pain, congestion, postnasal drip

Mouth/Throat- Teeth, gums, swallowing problems, soreness, redness, hoarseness

Respiratory- Chest pain, wheezing, cough, trouble breathing, asthma, TB, bronchitis, pneumonia, pleurisy

Cardiovascular- Chest pain, rheumatic fever, high blood pressure, palpitations, swelling, dizziness, faintness, blood clots

Gastrointestinal- Appetite, thirst, nausea, vomiting, bleeding, bowel habits, diarrhea, constipation, indigestion, gassiness, food intolerance, jaundice, chewing and swallowing problems

Urinary- Urinary frequency, pain, bed-wetting or daytime wetting, blood or pus in urine

Genital- Malformations, sores, discharges, hernia, pain, venereal disease, menstrual, pregnancy, or sexual problems

Musculoskeletal- Joint pain, stiffness, arthritis, swelling, back pain, muscle pain, cramps, redness, limitations in movements

Neurological- Seizures, blackouts, numbness, tingling, tremors, injuries

Endocrine- Thyroid problems, heat/cold intolerance, sweating, thirst, hunger, frequent urination, growth problems

Hematologic- Anemia, easy bruising/bleeding, transfusions

Psychological- Behavior, mood, sleep, depression, complaints of stomach aches or other body aches

HAS YOUR CHILD EVER HAD THESE BEHAVIORS?

	YES	NO	COMMENTS/Age
Irritability			
Poor appetite			
Colic			
Trouble keeping to schedule			
Constipation			
Trouble falling asleep			
Other sleep problems			
Rocking in bed			
Head banging			
Temper tantrums			
Breath holding			
Discipline problem			
Repetitive body movements			
Overactive			
Short attention span			
Mood changes			
Aggressive behavior			
Shyness with others			
Crying easily and often			
Very sensitive			
Poor eye contact			
Difficult to comfort			
Not cuddly or affectionate			
Difficulty in adapting to change in routine			
Other sensory or atypical behaviors			

Does Your Child:

Over-react to touch? No_____ Yes______Example___________Not anymore____

Over react to noises? No_____ Yes______Example___________Not anymore____

Walk on his/her toes? No_____ Yes______Example___________Not anymore_____

Seem pre-occupied with particular objects or activities?
No_____ Yes______ Example____
____

Please tell us to the best of your ability the age at which your child achieved the following milestones:

GROSS MOTOR:

Rolled over tummy to back ______
Sat alone ______
Crawled ______
Walked alone ______
Hopped on 2 feet ______
Rode a tricycle ______
Rode a bicycle ______

FINE MOTOR:

Picked up cheerio with fingers ______
Scribbled with crayon ______
Stacked blocks ______
Sorted shapes ______

LANGUAGE:

Smiled at you ______
Laughed out loud ______
Babbled ______
Said mama or dada ______
Said any other word ______
Waved goodbye ______
Pointed to show you something ______
Put two words together ______
Spoke in a full sentence ______

DAILY LIVING SKILLS

Held bottle _____
First fed self finger food _____
Was off all bottles _____
Toilet trained _____
Dressed self _____
Buttoned buttons _____
Tied shoes _____

ACADEMIC SKILLS
Named colors ______
Counted 1-10 ______
Recited the alphabet ______
Wrote name ______

Does anyone in the family—Grandmothers, Grandfathers, Aunts, Uncles, Cousins have the following?

Birth defects	
Early deaths	
Hearing difficulties	
Speech problems	
Vision loss/blindness	
Late walking	
Late talking	
Had a child with similar issues to this one	
Unusually early stroke or heart problems	
Cerebral Palsy	
Muscle Disorder	
Autism/Asperger's Disorder	
Intellectual disability/ Mental retardation	
Learning disabilities	
Seizures	
Depression for greater than 2 weeks	
Tics or Tourette's Syndrome Anxiety disorder	
Problems with attention, activity, & impulse control as a child	
Schizophrenia	
Bipolar Disorder	
Failure to graduate from high school	
Alcohol or drug abuse	
Other	

Please list all people who live with the patient:

NAME	AGE	RELATIONSHIP TO CHILD

List the patient's brothers, sisters, or parents that are not living with the patient. Please tell us if this is a change for the patient.

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Language/languages spoken in home____

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Have any of the following occurred in your family or extended family in the past year:

Serious Illness- Yes__________ No__________
Accidents- Yes__________ No__________
Moves- Yes__________ No__________
Deaths- Yes_________ No__________
Births Yes__________ No__________
Divorces or Separations Yes__________ No__________
Job Changes- Yes__________ No__________

	Patients MOTHER	Patients FATHER
School level completed		
Present occupation If previously employed outside of the home, and now staying home to provide childcare, where? Doing what?		
Age		
Health problems		

List early intervention/daycare/preschools/mother's day out/schools attended:

Name of Program or School:____________________ Dates:___________________________

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Has the child ever been asked to leave preschool?___________________________________

Has child ever been held back in school?____

Is there anything else we need to know about your child?

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Developmental Pediatric Services
12655 N. Central Expressway, Suite 300
Dallas, TX 75243
(972) 788-1858

Go 635 West, exit Coit, and turn left on N. Central Expressway, Turn right into the North Central Plaza building park. We are located in the 1st building on the left-hand side, North Central Plaza 1, The Prosperity Bank building.

Go 75 North, exit Coit, continue on to Coit and turn right at the third light, which is Banner Dr. We are in the last building, North Central Plaza 1, the Prosperity Bank Building, on the right-hand side.

Go 635 (LBJ) East, exit Coit, turn right onto Coit, and turn left onto Banner Dr. into the office park. We are in the last building, North Central Plaza 1,on the right-hand side.

Go 75 South, exit Mid Park stay straight on service road go under 635 (LBJ). Turn right into the North Central Plaza building park. We are located in the 1st building on the left-hand side, North Central Plaza 1, The Prosperity Bank building.