PROVIDENCE
Medical Group
Alaska

Developmental Clinic New Patient Form

Name of Patient: _____ Birthdate (Age):_____

Person Completing Form:_____ Relationship: _____Today's Date:_____

Primary language:_____ Will you need interpreter: Yes No

Primary Care Provider (last seen?): _____

Who recommended your child have a developmental evaluation? _____

What are your main concerns and reason for the visit?

_____
_____
_____
_____
_____
_____

When were you first concerned? _____

What therapies or interventions have been tried in the past? Did it help?

_____
_____
_____
_____
_____

List current and past providers (specialists, psychologists, speech therapy, etc) who have seen your child:

Name	Specialty	Age or date seen

List medications your child takes or has been prescribed in the past, including when and dose:

_____
_____
_____
_____
_____

Pregnancy:

Any prenatal testing, results?

_____
_____

During your pregnancy was there exposure to:

Medication: Yes / No

Alcohol: Yes / No

Drugs: Yes / No

Tobacco: Yes / No

Loss pregnancies? Yes / No

Was pregnancy planned? Yes / No

If you circled "Yes" to any of the above, please elaborate (when/what/how much?):

_____
_____
_____

Please circle and/or describe concerns during your pregnancy (e.g. diabetes, high blood pressure, poor weight gain, illness, infection, anemia or if you had care for high risk pregnancy):

_____
_____
_____

Birth:

Mother age at delivery ____ Father's age at delivery___

Place: _____ Birth weight: _____ Gestation (Full/Pre-term):_____

Delivery: Vaginal or C-section, any complications? _____

Was baby in special nursery/NICU? Yes / No APGAR scores (if known) __/__

Please circle if baby needed: medication, oxygen, phototherapy, feeding tube, resuscitation, NICU

Any difficulties after birth (seizures, poor weight gain, feeding problems, blood sugar problems, etc)?

_____
_____
_____

Developmental milestones (write age or leave blank if not yet, "**?"** if don't know):

Smiled	Babbled	First words	Combined words
Spoke phrases	Rolled over	Sat alone	Crawled
Pulled up	Walked alone	Pointed	Fed self
Used utensils	Bladder trained (day)	Bladder trained (night)	Bowel trained
Dressed self	Pretend play	Helped others	Best friend

Has your child ever regressed or loss developmental skills? Please explain.

_____
_____
_____

Medical History

Hx head injury (when)? Yes / No_____ Loss consciousness?: Yes / No _____

Seizure(s)?: Yes / No, with or without fever, when, how long did it last?_____

Sleep: apnea/snoring Y / N, daytime sleep/naps _____, nighttime _____# hrs, night wakings _____

Please explain and give dates (or age) if your child has had any **hospitalizations, surgeries, severe or recurrent illnesses** (include ear infections),:

_____
_____
_____
_____

Has your child been exposed to or witnessed trauma? Yes / No, Explain:_____

_____

Has your child had an EEG, CT scan, MRI or other tests in the past (When/Where)? _____
_____

Hearing and/or vision test (When/Results):_____
_____

Family

Who lives in the home? Please circle whether patient is your biologic, adopted, or foster child.

Name	Age	Relationship	Highest Education	Work	Health, learning, speech, behavior or mood problems?

List any relatives with seizures, genetic disorders, birth defects, medical problems, anxiety, depression, mental illness, deafness, tics/unusual movements, autism, intellectual disability, learning problems, alcohol/drug use:

Mother's side:

_____
_____
_____

Father's side:

_____
_____
_____

School

Please list all daycare/schools your child has attended.

School	Grade	Teacher concerns

Has your child had any special classes/504 Plan/IEP? _____

Has your child repeated a grade? Yes/No When? _____

Behavior

We would like to know a little about your child's behavior and temperament over time. Please place (+) present or (-) if the statement does not describe your child. Comment as needed.

	Infant (0-12 months)	Toddler (2-3 years)	Preschool (3-K years)	School age (K-12)
Difficulty feeding				
Difficulty sleeping				
Hard to console or calm				
Hard to put on schedule				
Social				
Overly active				
Happy				
Cries often				
Easy/Cooperative				
Hurts self				
Sensitive to sounds, touch, textures				
Aggressive behaviors				

Please explain any **safety concerns**:

Social

Describe how your child interacts with other children at school or in community:

_____
_____
_____
_____
_____
_____

Do you have concerns about how your child plays? What activities do your child enjoy?

_____
_____
_____
_____
_____
_____

What are your child's strengths? What does your child do well?

_____
_____
_____
_____
_____
_____

Please share anything else you would like for us to know about your child. What do you hope to get out of the visit?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____