carolina developmental pediatrics

INITIAL HISTORY FORM

(To Be Completed By Parent)

DEMOGRAPHIC INFORMATION:

Child's Last Name: _____ Child's First Name: _____ MI: ___
Child's Nick Name (the name you call him/her) : _____
Patient Birth date:_____/_____/_____ Sex: M F (Circle one) Today's Date: _____
Address _____ City _____
State _____ZIP _____
E-mail address: _____

Home Phone (____)_____ Work Phone (____)_____
Mothers Name: _____ Fathers Name: _____
Mothers Cell Phone: _____ Fathers Cell Phone: _____

Primary Insurance (circle one): **Aetna BCBS Cigna Medicaid Other** _____
Is Pre-authorization required: Yes No (circle one)
Primary Insurance Holder: _____ DOB: _____
Employer : _____
Insurance ID number :_____ Group number: _____

REFERRAL CONCERNS:

Please indicate what concerns you have regarding your child.

1 _____

2 _____

3 _____

4 _____

Additional Information:

_____

_____

Who referred you to us? _____ Primary MD: _____

Please help us understand more about your child by completing the following sections:

PREGNANCY	Yes	No	Comments
Was the pregnancy planned?	___	___	_____
Was prenatal care begun in the first trimester?	___	___	_____
Were medications used during pregnancy?	___	___	_____
Did the mother drink any alcohol? (how much)	___	___	_____
Did the mother smoke cigarettes? (how much)	___	___	_____
Did the mother use illicit drugs? (if yes, indicate)	___	___	_____
Were there any problems during the pregnancy?	___	___	_____

BIRTH	Yes	No	Comments
Was the birth full-term?(if not how many weeks)	___	___	_____
Was the delivery a cesarean	___	___	_____
Were there any problems with delivery ?	___	___	_____
What was the birth weight?	_____ lbs. _____oz.		
Were there any difficulties at birth?	___	___	_____
Was the child a twin or triplet?	___	___	_____
Were there any birth defects noted?	___	___	_____
Were there any feeding difficulties?	___	___	_____
Did the child stay in the hospital longer than 3 days?	___	___	_____
Were there any other problems?	___	___	_____

PAST MEDICAL HISTORY	Yes	No	Comments
Did the child have frequent ear infections?	___	___	_____
Did the child have any serious infections?	___	___	_____
Is there a history of poor weight gain?	___	___	_____
In the past have there been any difficulties with hearing?	___	___	_____
In the past have there been any difficulties with vision?	___	___	_____
Does the child suffer from allergies? (If so to what)	___	___	_____
Have there been difficulties with bowel movements?	___	___	_____
Have there been difficulties with urination/bedwetting?	___	___	_____
Does the child take any medications/supplements?	___	___	_____

List

1 _____

2 _____

3 _____

Has child had any surgeries?	___	___	_____
Has the child ever been hospitalized?	___	___	_____
Are there other medical problems?	___	___	_____

REVIEW OF SYSTEMS	Yes	No	Comments
Does the child have difficulties with any of the following?:	___	___	_____
Headaches	___	___	_____
Stuffy nose	___	___	_____
Trouble breathing	___	___	_____
Noisy breathing during sleep	___	___	_____
Trouble falling or staying asleep	___	___	_____
Daytime sleepiness	___	___	_____
Difficulty getting going in the morning	___	___	_____
Constipation	___	___	_____
Loose stools	___	___	_____
Difficulty hearing	___	___	_____
Difficulty with vision	___	___	_____
Frequent stomachaches	___	___	_____
Bedwetting	___	___	_____
Staring spells	___	___	_____
What time does the child go to sleep?	_____		pm
What time does the child wakeup?	_____		am

DEVELOPMENTAL HISTORY	Yes	No	Comments
Was early development normal/typical?	___	___	_____
Has the child lost any skills?	___	___	_____
Please indicate the age at which the child:			
Rolled over	_____		mos.
Sat up alone	_____		mos.
Crawled	_____		mos.
Walked alone	_____		mos.
Ran well	_____		yrs.
Rode tricycle	_____		yrs.
Spoke first words	_____		mos.
Put two words together	_____		mos.
Spoke so others could understand	_____		yrs.
Able to hold the bottle	_____		mos.
Used a spoon to feed self	_____		mos.
Was able to tie shoes	_____		yrs.
Could dress independently	_____		yrs.

Comments:

_____

_____

_____

FAMILY HISTORY	Yes	No	Relationship to Patient
Anybody in the family been diagnosed with any of the following?			
Attention Problems ADHD	___	___	_____
Autism	___	___	_____
Developmental delay/mental retardation	___	___	_____
Learning problems/dyslexia	___	___	_____
Depression	___	___	_____
Anxiety	___	___	_____
Bipolar disorder	___	___	_____
Other psychiatric problems	___	___	_____
Thyroid	___	___	_____
Hearing problems	___	___	_____
Vision problems	___	___	_____
Bedwetting	___	___	_____
Other :	___	___	_____

SOCIAL HISTORY	Yes	No	Comments
Does the child live with their biological parents?	___	___	_____
Does the child have any brothers? (List ages)	___	___	_____
Does the child have any sisters? (List ages)	___	___	_____
Does the child attend school or day care?	___	___	_____

Name of school or day care: _____ Grade: _____

Please list some of the child's favorite activities:

_____

_____

_____

How old is the child's mother? _____ years old Occupation: _____

How old is the child's father? _____ years old Occupation: _____

PREVIOUS ASSESSMENTS

Type	Date	Result

Please return to: **1001 W. Williams Street Suite 104, Apex, NC 27502**

or Fax to: **919-362-5409**