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 ☐ 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 : **Aetna** ☐ **BCBS** ☐ **Cigna** ☐ **Medicaid** ☐ **Other** _____
Is Pre-authorization required: Yes ☐ No ☐
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**