Office of Elizabeth A McMorran, NP

CHILD'S DEVELOPMENTAL INFORMATION

Today's Date:_____ **Referred by:**_____

CHILD'S FULL NAME_____ Child's DOB:_____ Gender: _____

Father's Name: _____ _____DOB: _____

Address:_____

Phone: Home: _____ Cell: _____Work: _____ Father's Occupation: _____

Mother's Name: _____ DOB: _____

Address:_____

Phone: Home: _____ Cell: _____Work: _____ Mother's Occupation: _____

If parents are divorced: Date of Divorce: _____ Is there joint custody?_____

If not joint custody, who has physical custody and medical decision making authority: _____

Any current or pending family court matters such as custody disputes or involvement with court ordered treatment? _____

_____

Family History:

Please list family members living in your home:

Name: Relationship: Age

_____

_____

_____

_____

_____

_____

If divorced, please list family members living in other parent's home:

Name: Relationship: Age

_____

_____

_____

_____

_____

_____

About your child:

Please describe your child's temperament: _____

_____

_____

Pregnancy and Birth:

Medical interventions to conceive? _____ Please describe: _____

Health problems during the pregnancy? _____ Please describe: _____

Did mother take any medications during the pregnancy? _____ Please list: _____

Substance use during pregnancy (Please circle)

cigarettes alcohol marijuana opioids methamphetamine crack/cocaine mis-use of prescription drugs

Other substances? _____

Gestational age: _____ Delivery: vaginal or C section (Please circle)

Complications during delivery? _____

Birth weight: _____ Went home with mother or required extra time in the hospital? _____

In the NICU? _____ How long? _____

Developmental History:

Any delays with talking? _____ With walking or motor skills? _____

Toilet trained at age: _____ Bed wetting? _____ Until what age? _____

Therapies:

Counselor's name and address: _____

_____

Child ever evaluated before? _____ When? _____ By Whom: _____

Results or Diagnosis: _____

If medication was prescribed, name and strength of medication(s): _____

_____

_____

Any psychiatric hospitalizations? _____ When: _____ Where: _____

For what? _____

Any self-harming behaviors (cutting, scratching, head banging, hitting self)? _____

Aggression toward others? _____

IOP or Day Treatment attendance: _____

Any concerns about alcohol, nicotine or other substance use with your child? _____

Any involvement with the Juvenile Justice system? _____ Any arrests? _____

DDD services: _____

Other therapies: _____

Medical History:

Please list any chronic health conditions: _____

Is your child allergic to any medication, food or substances? Please list: _____

Does your child take any medication on a daily basis? Please list: _____

_____

Any vitamins, minerals, supplements, herbal preparations, homeopathic formulations? Please list: _____

_____

Is your child immunized? _____ Are they up to date: _____

Child's Health Care Provider Name and Address and Phone number:

_____

_____

_____

May we contact the office with any questions about your child's health status or to coordinate treatment? _____

Family History of Emotional/Behavioral Problems:

Depression: _____
Anxiety: _____
Bipolar Disorder/Manic Depression: _____
Suicide Attempts/Cutting and other self-harming behaviors: _____
ADHD/ADD: _____
Asperger's/Austim/PDD NOS/ High Functioning Autism: _____
Alcohol Problems: _____
Substance Abuse: _____

Education

School District: _____ Name of School: _____ Grade: _____
IEP or 504 in place: _____ Designation for services: _____ Repeat a grade?: _____
Suspensions from school? _____
Other difficulties at school? Please list: _____
_____
_____

Reason for today's visit:

_____
_____
_____
_____
_____
_____

PLEASE NOTE: The nurse practitioner is not able to appear in court or prepare any reports for the court. She does not get involved in any custody disputes and will not testify or prepare any documents related to custody or other legal matters for parents.

_____

Name of person completing form Signature Date