Pediatric Specialists of Virginia
Children's National INOVA

Neurodevelopmental Pediatrics
New Patient Intake

INSTRUCTIONS

Allow yourself at least an hour to complete this packet in its entirety. Please do not leave any blanks. If something does not apply, please write N/A. If you do not know the answer, please write unsure.

Please email the completed packet to: Developmentalpeds@PSVCare.Org

DEMOGRAPHICS

Date Completed: _____
Child's Full Name: _____
Date of Birth: _____
Age of Child: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email Address: _____
Primary language spoken at home: _____
Other languages spoken at home: _____
Person completing form: _____ Relationship to child: _____
Who recommended this appointment? _____
Pediatrician: _____

PRIMARY CONCERNS

You are concerned about your child's (please check all that are relevant):
☐ Ability to learn/ trouble in school
☐ Attention/hyperactivity problems
☐ Behavior
☐ Symptoms that may indicate Autism
☐ Other, including previously given diagnoses, please specify:
_____

Does your child have violent behavioral outbursts? No☐ Yes☐

Has your child caused physical harm to someone or something in the past? No☐ Yes☐

Briefly describe your child's current difficulties and the age at which they began:
What first caused you to become concerned and at what age?
_____

Who raised these concerns? _____

What are your child's strengths? _____

In general, how does your child let you know what he/she wants or needs?
_____

DEVELOPMENTAL EVALUATIONS AND INTERVENTION:

Does, or did, your child receive Early Intervention services? No☐ Yes☐

If yes, which type: _____

What services does your child currently receive (mark boxes below to show private, educational, or both)?

	Private	Educational	Early Intervention
Speech language therapy	☐	☐	☐
Occupational therapy	☐	☐	☐
Physical therapy	☐	☐	☐
Psychological counseling	☐	☐	☐
Social skills	☐	☐	☐
Behavior therapy	☐	☐	☐
ABA therapy	☐	☐	☐
Other (list) _____	☐	☐	☐

What services did your child previously receive (mark boxes below to show private, educational, or both)?

	Private	Educational	Early Intervention
Speech language therapy	☐	☐	☐
Occupational therapy	☐	☐	☐
Physical therapy	☐	☐	☐
Psychological counseling	☐	☐	☐
Social skills	☐	☐	☐
Behavior therapy	☐	☐	☐
ABA therapy	☐	☐	☐
Other (list) _____	☐	☐	☐

Please email copies of any evaluation or therapy reports.

Has your child ever had a Developmental evaluation? No☐ Yes☐

If yes, please list when and where: _____
What were the results/diagnosis? _____
Please email copies of the report.

Has your child ever had a private psychological/neuropsychological evaluation or an assessment such as vision therapy or biofeedback? No☐ Yes☐

If yes, please list when and where: _____
What were the results/diagnosis? _____
Please email copies of the report.

SCHOOL/ /DAYCARE:

Does your child attend school or daycare? No☐ Yes☐
What is the name of your child's current school or daycare? _____
What is your child's current grade level? _____
Has your child ever repeated or been recommended to repeat a grade? No☐ Yes☐
Has your child been suspended, expelled, or asked to leave school?
Is your child involved in any other organized activities or sports? No☐ Yes☐
If yes, please list: _____
Does your child have an educational disability, according to the school? No☐ Yes☐
If yes, please list: _____

Does your child have (check all that apply)?
☐ IEP ☐ 504 Plan

If applicable, under what code is your child eligible?
☐ Autism
☐ Developmental delay
☐ Specific learning disability
☐ Intellectual disability
☐ Other, please list _____

Please describe your child's learning strengths and weaknesses:
_____

BIRTH HISTORY

Is your child adopted? _____
Biological mother's age at birth: _____ Biological father's age at birth: _____
Was baby born early? No☐ Yes☐
If yes, how many weeks early? _____
Birth weight: _____ lbs _____ oz
Vaginal birth☐ Cesarean section ☐
If Cesarean, please list the reason_____
Did your child pass his/her newborn hearing test in the hospital? No☐ Yes☐
Did your child have a normal newborn screening blood test? No☐ Yes☐
How many days did your child stay in the hospital after birth? _____
Was the child kept in the special care nursery or NICU? No☐ Yes☐
If yes, please explain: _____
Were there any problems or illnesses in the first month of life? No☐ Yes☐
If yes, please explain: _____
During pregnancy did the mother experience any medical problems, toxic exposures (e.g. lead), illness, infection, or fevers? No☐ Yes☐
If yes, please explain: _____
During pregnancy did mother use medications, alcohol, tobacco, or recreational drugs? No☐ Yes☐

If yes, please explain: _____

Did the parents:

☐ Have history of infertility
☐ Have a history of miscarriage
☐ Use assistive reproductive technology

Describe your child as an infant in a few words: _____

MEDICAL HISTORY

Does your child have any allergies? No☐ Yes☐

If yes, please list allergen and type of reaction: _____

Does your child take any medications? No☐ Yes☐

If yes, please list name, dosage, prescriber and why taking: _____

Has your child ever been hospitalized after birth? No☐ Yes☐

If yes, please explain when, where and why: _____

Has your child ever had surgery? No☐ Yes☐

If yes, please explain when, where and why: _____

Has your child ever had any medical problems? (Including but not limited to frequent ear infections, asthma, wheezing, eczema, heart problem, croup, chronic cough, vocal or motor tic, problems feeding or gaining weight, etc.) No☐ Yes☐

If yes, please explain: _____

Are your child's immunizations up to date? No☐ Yes☐

If no, what vaccines is your child missing? _____

Do you plan on vaccinating your child fully? No☐ Yes☐

Has your child ever had a brain injury/concussion? No☐ Yes☐

If yes, please explain and give dates: _____

Has your child ever had a seizure or staring spell where you have difficulty getting his/her attention? No☐ Yes☐

If yes, please explain and give dates: _____

Is there anything else we should know about your child's health? _____

Has your child's vision been checked? No☐ Yes☐

If yes, please list when, where, and the result of the test: _____

Has your child's hearing been checked? No☐ Yes☐

If yes, please list when, where, and the result of the test: _____

Has your child ever seen a Genetic Specialist? No☐ Yes☐

If yes, please explain when, where and why: _____

Have any of the following tests been performed? Check all that apply.

Blood Tests:

☐ Ammonia, If yes list when and where performed: _____
☐ Lactate, If yes list when and where performed: _____
☐ Pyruvate, If yes list when and where performed: _____
☐ Lead Level, If yes list when and where performed: _____
☐ Thyroid Function, If yes list when and where performed: _____
☐ Serum Amino Acids, If yes list when and where performed: _____

Urine Tests:

☐ Metabolic Screen, If yes list when and where performed: _____
☐ Organic Acids, If yes list when and where performed: _____
☐ Amino Acids, If yes list when and where performed: _____

Other Tests:

☐ MRI or MRA of the brain, If yes list when and where performed: _____
☐ Electroencephalogram (EEG), If yes list when and where performed: _____
☐ Brainstem Auditory Evoked Response (BAER), If yes list when and where performed: _____
☐ Echocardiogram (ECHO), If yes list when and where performed: _____
☐ Any other testing not listed here: _____

SLEEP HISTORY

Do you have concerns about your child's sleep? No☐ Yes☐
If yes, please explain: _____

Does your child (please check yes or no):

Yes	No	
☐	☐	Fall asleep independently
☐	☐	Have trouble getting to sleep
☐	☐	Rise early
☐	☐	Seem sleepy, falls asleep during the day
☐	☐	Snore
☐	☐	Wake during night

DIET HISTORY

Do you have concerns about how or what your child eats? No☐ Yes☐
If yes, please explain: _____
Does your child eat a limited variety of foods? No☐ Yes☐
If yes, please explain: _____
Do adults feed your child? No☐ Yes☐

Does your child (check all that apply):
☐ Feed him/herself
☐ Gag or vomit

☐ Stuff food in his/her mouth
☐ Have trouble chewing
☐ Have trouble swallowing

DEVELOPMENTAL HISTORY

Please list the age at which the following milestone was first seen ***or*** check N/A if child not performing milestone yet.

LANGUAGE SKILLS:

Babbled repeated consonant sounds like "mamama…" or "babababa…", Age___ ☐ N/A
Used "mama" and/or "dada" specifically to call that person, Age___ ☐ N/A
Pointing to pictures in books, Age___ ☐ N/A
Spoke first words other than "mama", "dada", or names, Age___ ☐ N/A
Follow instructions with gestures, Age____ ☐ N/A
Put two words together in phrases, Age____ ☐ N/A

SOCIAL SKILLS:

First responsive social smile, i.e. child smiling back at parent, Age___ ☐ N/A
Pointing to request, Age____ ☐ N/A
Point to share interests, Age____ ☐ N/A
Simple pretend play i.e. feeding a doll or stuffed animal, Age____ ☐ N/A

GROSS MOTOR SKILLS:

Sat alone, Age_____ ☐ N/A
Crawled, Age_____ ☐ N/A
Walked independently, Age_____ ☐ N/A
Pedaling tricycle, Age_____ ☐ N/A
Ride a bicycle without training wheels, Age___ ☐ N/A

FINE MOTOR / ADAPTIVE SKILLS:

Fed self with spoon, Age_____ ☐ N/A
Toileting, Age_____ ☐ N/A
Able to remove shoes, Age___ ☐ N/A
Puts shoes on correct feet, Age_____ ☐ N/A
Able to zip and unzip if shank is already connected, Age___ ☐ N/A
Able to button 3-4 buttons, Age_____ ☐ N/A
Able to fully dress on his/her own, Age___ ☐ N/A
Tied shoes, Age_____ ☐ N/A

What percentage of your child's speech do you estimate a stranger could understand?
☐ 25% ☐ 50% ☐ 75% ☐ 100%

Has your child lost any skills that he or she previously had (a gained developmental milestone that has been completely lost)? No☐ Yes☐
If yes, please explain, include when gained and when lost: _____

BEHAVIORAL HISTORY

How old does your child act? _____

What are your child's main (favorite) play interests? _____

Does your child have any behavioral problems in preschool or day care? No☐ Yes☐
If yes, please explain: _____

Does your child have any behavioral problems at home? No☐ Yes☐
If yes, please explain: _____

Do you feel your child's interactions with other children are typical for his/her age? No☐ Yes☐

Does your child have problems separating from parent (s)? No☐ Yes☐

Does your child have any major fears? No☐ Yes☐
If yes, please explain: _____

Does your child have any repetitive behaviors (i.e., hand flapping, head banging, rocking and/or walking in circles)? No☐ Yes☐
If yes, please explain: _____

Does your child have any ritualistic behaviors (i.e., needs objects in a certain place before going to bed, has to go the same route every time)? No☐ Yes☐
If yes, please explain: _____

Is your child bothered by the sight, sound, taste, texture, or feel of things that do not seem to bother other people or yourself (i.e. bright lights, clothing, being touched, and texture of food)? No☐ Yes☐
If yes, please explain: _____

Is your child aggressive toward others? No☐ Yes☐

Does your child ever do things to injure himself/herself? No☐ Yes☐

Do you or others feel that your child is (check all that apply):
☐ Disorganized
☐ Easily distracted
☐ Fidgety
☐ Has problems focusing on things for long periods
☐ Hyperactive
☐ Impulsive
☐ Overactive

☐ Moody

FAMILY/SOCIAL HISTORY

Who lives in the child's primary home?

	Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

Does the child have a secondary home? No☐ Yes☐

If yes, who lives in secondary home?

	Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

Parents are:
☐ married ☐ divorced ☐ separated ☐ never married ☐ living together
☐ living separately ☐ working away from home for extended time period

Father's highest level of education: _____ Occupation: _____
Mother's highest level of education: _____ Occupation: _____

Other family members regularly involved with the child:

	Name	Age	Relationship
1.			
2.			

Other adults regularly involved with the child:

	Name	Age	Relationship
1.			
2.			

FAMILY MEDICAL HISTORY

☐ Adopted/Unknown

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Name:
DOB:

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Does any member of the family have the following? If yes, place a mark the appropriate column.	Mother	Father	Sibling	Aunt / Uncle	Cousin	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Hearing problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vision problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Speech problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Developmental delay	☐	☐	☐	☐	☐	☐	☐	☐	☐
Slowness in talking	☐	☐	☐	☐	☐	☐	☐	☐	☐
Slowness in walking	☐	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual disability	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning difficulty/learning disability	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hyperactivity/ Attention Problems/ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism/Asperger Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mania/Bipolar disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other emotional problems (specify) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep problems (specify)_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tics	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other genetic disorder (specify) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems (specify) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease (specify) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease/High blood pressure (specify age and type) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sudden death under Age 50 from heart attack, stroke, or unknown cause (specify age and type)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (specify type) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

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