Developmental Follow-Up

Mary Allare, M.D., Virginia Valenzuela, M.S., N.N.P. Maria Thillet, M.S., NNP., Deborah Calhoun, M.D.
10250 N. 92nd Street, Suite 118, Scottsdale, AZ 85258 • (480) 767-1490 Fax 855-224-0059

New Patient Intake Form

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

REASON FOR REFERRAL/EVALUATION:

_____

_____

_____

Referred by: _____

BIRTH/PREGNANCY HISTORY

Birth weight: _____ Length of Pregnancy (weeks): _____

Complications during pregnancy? _____

_____

During the pregnancy was there:

Smoking: _____ Alcohol Consumption: _____ Drug Use: _____

_____

Delivery: Induced _____ C-section _____ Breech _____ Forceps_____

Length of hospital stay if baby stayed longer than the mother:

_____

What were the reasons for the extended stay? _____

_____

_____

Were there any issues during the first month at home? _____

_____

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MEDICAL HISTORY

Immunizations up to date? _____

If not, list reasons _____

HAS YOUR CHILD EVER HAD:

Health	YES	NO	AGE	DETAILS
Ear Infections				
PE tubes				
Seizures				
Fevers with viruses				
Trouble eating				
Special diets				
Skin problems				
Other				
Constipation				
Trouble hearing				
Trouble seeing				

Does your child have any allergies? _____

_____

Has your child been evaluated by physicians other than their pediatrician or PCP?

_____

_____

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Is your child taking any medications? _____

_____

_____

Has your child had any previous hospitalizations, injuries or surgeries?

_____

_____

_____

_____

_____

AT WHAT AGE DID YOUR CHILD MEET THESE MILESTONES?

Roll Over

_____

Sat Alone

_____

Army Crawl

_____

Walked holding on to furniture

_____

Toilet trained

_____

Smile

_____

Drink from a cup

_____

Crawl hands and knees

_____

Walked without help

_____

Talk in short phrases

_____

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DOES YOUR CHILD:

	YES	NO	COMMENTS / EXAMPLE / AGE
Dislike getting hands dirty			
Over-react to touch			
Over react to certain odors			
Over react to certain lights			
Over react to noises			
Dislike going barefoot			
Dislike wearing shoes			
Dislike wearing clothes			
Dislike having teeth brushed			
Dislike swinging			
Seem attracted to touch things in an unusual fashion			
Seem attracted to smell things unusually			
Seem to taste things that aren't food			
Seem pre-occupied with particular objects or activities			

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HAS YOUR CHILD EVER HAD THESE BEHAVIORS?

	YES	NO	COMMENTS / AGE
Irritability			
Colic			
Trouble keeping to schedule			
Sleep problems			
Rocking in bed			
Head banging			
Temper tantrums			
Breath holding			
Repetitive body movements			
Overactive			
Short attention span			
Mood changes			
Aggressive behavior			
Shyness with others			
Crying easily and often			
Very sensitive			
Poor eye contact			
Difficult to comfort			
Not cuddly or affectionate			
Difficulty in adapting to change in routine			

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Please describe any other behavioral issues with your child:

_____

_____

_____

FAMILY HISTORY

Please list the names, ages and relationship of others living in the home:

Name	Relationship	Age

List members of the immediate family not living at home, where they are living, and reason:

_____

_____

Language/s spoken at home: _____

PARENTS

	MOTHER	FATHER
School Level Completed		
Present Occupation		
Age		
Health Problems		

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Has there been any extended family history of the following in aunts, uncles, cousins, grandparents? Please check/list condition and the relationship to your child.

✓	Condition	Relationship to the Child
	Cancer	
	Diabetes	
	Asthma	
	Heart Problems	
	Hearing	
	Neurological problems	
	Aggressiveness	
	Anger	
	ADHD	
	Learning Disabilities	
	School Problems	
	Substance Abuse	
	Depression	
	Anxiety	
	Issues similar to your child	

Who cares for your child? _____

_____

List any pets in your house: _____

_____

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Has your child had any **special evaluations or testing done**? If so, please list type of testing or specialist seen, and when and where the evaluation was done. Also list any therapies (physical, speech, occupational, emotional or behavioral and when/where). If possible, please bring copies of these to the visit.

_____

_____

_____

_____

_____

List daycare/preschools/mother's day out/other schools attended:

Name of Program/School	Dates:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Describe any special help the child is presently receiving:

_____

_____

_____

_____

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ACTIVITIES

Which does your child like to do?

What activities has your child been involved in?

What has been difficult about parenting your child?

What do you enjoy most about your child?

Does your child have any special talents/interests?