carolina developmental
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INITIAL HISTORY FORM (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)

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): **BCBS** **Aetna** **Cigna** **United** **Medicaid** **Other** ___________

Is Referral or 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 fullterm?(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 ______________________________

	Yes	No	Comments
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

Anybody in the family been diagnosed with any of the following?

	Yes	No	Comments
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

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**