DEVELOPMENTAL BEHAVIORAL PEDIATRIC CLINIC

Name: Clinic date:
Birth date: Address:
age: Alaska native? y/n Tribal affiliation?
name of person answering questions:
relationship to client:
Referring physician/nurse:

PRIMARY PROBLEM (Why are you here?):

Who does the child live with? Who has legal custody?

If shared custody, describe pattern:

Has the child ever been removed or placed outside the biologic home?
why?
How many times?

Legal issues (permanence plan, GAL, pending court action...):

History of child abuse/neglect:
Child as victim (neglect, physical, sexual abuse):

Child as witness (domestic violence, sibling/other abuse):

Has the child received therapy related to this history?

FAMILY HISTORY: Mother's side Father's side both
birth rank
siblings
Medical conditions:

Learning problems:
(reading, ADHD...)

Mental Health:
(bipolar d/o, depression,
substance abuse,
history of abuse/neglect...)

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MEDICAL HISTORY:

How far along was the pregnancy when the mother became aware?
Were there any illnesses, or were medications used in pregnancy?

Were tobacco, drugs, or alcohol used in pregnancy? (how do you know?)
mother: father:

Was there anything else different about the pregnancy (premature or late, abnormal tests, etc)?:

Were there problems with the delivery?

Any illness or other problem before discharge home after birth?

Has s/he had any problems with eating or growing?

Were there problems during infancy with sleep, colic, over reaction to noise, touch, other sensation?

Has s/he ever had a brain injury from an accident or an infection?

Has the child been placed in a mental health or corrections setting?

Have there been other developmental or mental health evaluations?
(age of child, results - please provide copies of reports)

Mental Health Diagnoses:
Medications tried and effects (who prescribed):

Current medication/prescriber:

Surgeries:
Allergies:
Special diets or supplements:

Immunizations up to date? Vision, hearing, other sensory issues?
Sleep
Typical bedtime/waking time: Time to sleep onset:
Snoring or pauses in breathing?:
Frequent waking in night? y/n __/week Needs help/attention? y/n
Nightmares, sleepwalking, other abnormalities:
Daytime wakefulness (sleepy, wide awake, needs naps):
Any attempts with medication or other therapy?
Does the child get enough sleep?

DEVELOPMENTAL BEHAVIORAL PEDIATRIC CLINIC

DEVELOPMENTAL HISTORY:

Has anyone ever worried about this child's development?

Milestones, with best guesses (exact dates or ages are not important):

Age when: s/he first sat alone:
s/he first crawled:
s/he first walked:
at first single words:
at first word combinations:
toilet trained for urine: for stool:

Behavior (describe problems, with age first seen):

Previous evaluation or therapy? age of child/result:

Medicines tried/result:

Has child lived with others who have similar behavior?

EDUCATION HISTORY

Current school and grade:

Was the child ever held back? When/why?

Special Education program? Is there an IEP? Date last plan:
(please provide copy)

When did Special ed services start?

Learning problems (when first noted?):

Behavior problems at school:

Testing results: IQ tests? (age, results):

DEVELOPMENTAL BEHAVIORAL PEDIATRIC CLINIC

Name: Age:

PHYSICAL EXAM:

Head Circumference: ___cm __% Height: ___cm/in __% Weight: ___kg/lb __%

Palpebral fissures _____/_____cm (R/L) Upper lip/Philtrum ___/___

Notable findings on exam:

Neuromuscular exam:

Muscle tone, bulk, strength:

Motor coordination:

Reflexes:

Social/cognitive function:

Interactive style:

Personal/social connection:

Ability to communicate

expressive ability - verbal speech

nonverbal strategies

receptive ability

DEVELOPMENTAL BEHAVIORAL PEDIATRIC CLINIC

NAME: DATE:

DIAGNOSTIC IMPRESSION:

Problem List and Plan of Care:

1.

2.

3.

4.

IMMEDIATE NEXT STEPS:

Recommended return to this clinic:

Time in evaluation:
(Over half of ____ minute visit spent in consultation: Y / N)

(please direct questions to Vickie Tinker at (907) 714-6648)