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PEDIATRIC NEURODEVELOPMENTAL INTAKE

PATIENT DEMOGRAPHICS

Child name: _____ Today's date: _____

Date of birth: _____ Age: _____ Gender: _____

Patient is: (Biological) (Adopted) (Fostered) If adopted/fostered at what age: _____

School: _____ Grade: _____ District: _____

Home Address: _____ City: _____ Zip Code: _____

Individual completing this form: _____

Preferred contact number: _____ Email: _____

Referral source: _____ May we thank this person: (Yes) (No)

Previous family members we have evaluated (if applicable): _____

Parent/Guardian (1): _____ Relationship to child: _____ Age: _____

Address (if different than above): _____

Phone: _____ Email: _____ Occupation: _____

Parent/Guardian (2): _____ Relationship to child: _____ Age: _____

Address (if different than above): _____

Phone: _____ Email: _____ Occupation: _____

Parents/Guardians relationship: (Married) (Separated) (Divorced) (Deceased) **Custody:** (Sole) (Joint)

Do both parents agree to this evaluation: (Yes) (No) *If no, please explain:* _____

_____

Please note, if sole custody arrangement is marked you must send legal documentation within 7 days after scheduling the appointment. In cases of joint custody, we require both legal parents/guardians' signatures agreeing to the evaluation. If you cannot provide these documents or both signatures, we can't proceed with the evaluation and refund your scheduling fee*

REFERRAL INFORMATION

Problem statement/Reason for referral: _____

_____

_____

_____

Describe your child's strengths: _____

_____

_____

Describe your child's weaknesses: _____

_____

_____

What do you hope to learn as a result of the evaluation: _____

_____

_____

PREGNANCY, DELIVERY, AND INFANCY

Mother's age at delivery: _____ **Father's age at delivery:** _____ **Number of prior pregnancies:** _____

Prior miscarriages: (Yes) (No) **Was a fertility specialist consulted:** (Yes) (No)

Known Health Problems of Mother During Pregnancy (*circle all that apply*):

Accidents	Allergies	Alcohol Use	Anxiety	Antibiotics
Blood Incompatibility	Depression	Diabetes (Gestational)	Emotional Abuse	Fever
Hyperemesis Gravidarum	Hypertension	Illicit Drug Use	Mental Illness	Physical Abuse
Pitocin Used	Preterm Labor	Other Medications	Sexual Abuse	Sexually Trans. Disease
Strep-B Infection	Other:			

If endorsed, please explain circumstances: _____

_____

Delivery term: (Full Term) (Premature) **Gestational age at delivery** (ex. 38 weeks): _____

Time spent in labor: _____ **Delivery method:** (Vaginal) (Scheduled C-section) (Emergency C-section)

Birth weight: ___ lbs. ___ oz. **APGAR Score:** _____

Delivery/Birth Complications (circle all that apply)

Breech Positioning	Breathing Concerns	Epidural	Fetal Distress	Forceps/Vacuum
Jaundice	Meconium Staining	Nausea	Nuchal Cord	Pitocin Required
Phototherapy	Other:			

If endorsed, please explain circumstances: _____

_____

Was your child nursed: (Yes) (No) **Duration nursed for:** _____ **Feeding Specialist consulted:** (Yes) (No)

Any difficulties with: (Latching) (Feeding) (Gaining Weight) (Gastrointestinal) (Sleep) (Failure to Thrive)

Infant temperament: (Typical) (Slow to Warm Up) (Colic Distress) (Disengaged/Nonresponsive)

Any other concerns during infancy: _____

MOTOR DEVELOPMENT

Sat alone (age): _____ **Crawled** (age): _____ **Stood alone** (age): _____ **Walked alone** (age): _____

Any unusual milestone presentations (i.e., army crawl, skipping milestone, etc.): (Yes) (No)

If yes, please explain: _____

Were gross motor skills delayed or awkward compared to siblings/peers *(i.e., running, skipping, climbing, biking, playing catch, etc.)*: (Yes) (No) *If yes please explain:* _____

_____

Hand Dominance: (Right) (Left) (Ambidextrous) **Was handedness established early on:** (Yes) (No)

Family history of left-handedness: (Yes) (No)

Were fine motor skills delayed or awkward compared to siblings/peers: *(i.e., grasping utensils, writing, fastening, buttoning, zipping, tying shoelaces, etc.)*: (Yes) (No) *If yes, please explain:* _____

_____

Level of motor activity: (Typical) (Overactive) (Underactive) **Prone to motion sickness:** (Yes) (No)

Repetitive motor movements/tics *(i.e., heavy blinking, unusual finger mannerisms, neck movements, body twitching, etc.)*: (Yes) (No) *If yes, please explain:* _____

Routine motion seeking behaviors *(i.e. rocking, flapping, swinging, spinning, etc.):* (Yes) (No)

If yes, please explain: _____

Has your child undergone an Occupational or Physical Therapy evaluation: (Yes) (No) *If yes, please list below:*

Provider Name: **Date(s) Seen:** **Condition for Treatment:**

_____

_____

SPEECH & LANGUAGE DEVELOPMENT

Child's primary language: _____ **Bilingual:** (Yes) (No) **Other languages spoken at home:** (Yes) (No)

Spoke first word (age): _____ **Simple phrases (2-3 words)** (age): _____ **Speaking in full sentences** (age): _____

Known Speech/Language Concerns (*circle all that apply*)

Articulation Problems	Difficulties Processing Sounds	Frequent Ear Infections	Late Drooling
Morphological Errors	Poor Chewing	Poor Sucking	Slow to Learn Counting
Slow to Learn Colors	Slow to Learn Alphabet	Speech Delays	Stuttering
Repeating Sounds	Repetitive Vocalizations	Using Social Language	Other:

If endorsed, please explain: _____

_____

Has your child undergone a Speech-Language evaluation: (Yes) (No) *If yes, please list below:*

Provider Name: **Date(s) Seen:** **Condition for Treatment:**

_____

_____

MEDICAL HISTORY

Child's Pediatrician/Physician: _____ **Last seen on:** _____

Are they prescribed medication: (Yes) (No) *If yes, please list medication* (type/dosage): _____

_____

Last Vision Exam: _____ **Visual Issues:** (None) (Nearsighted) (Farsighted) (Nystagmus) (Strabismus)

Last Hearing Exam: _____ **Hearing Issues:** (None) (Partially Deaf) (Hearing Aids) (Sensitivities)

List any serious hospitalizations/surgeries (date/reason): _____

_____

Have they undergone any Neuroimaging (MRI, CT, PET) **or Neuroelectrical Studies** (EEG): (Yes) (No)

If yes, please explain (date/reason): _____

Known Medical Conditions (*circle all that apply*)

Addiction	Asthma	Allergies	Cerebral Palsy	Concussion
Diabetes	Ear Infections (Tubes)	Eating Difficulties	Encephalitis	Encopresis
Enuresis	Epilepsy/Seizure	Febrile Seizures	Gastrointestinal Issues	Genetic Condition
Headaches	Loss of Consciousness	Meningitis	Nail Biting	PANS/PANDAS/BGE
Self-harm	Sensory Sensitivities	Sleep Difficulties	Sleepwalking	Sleep Talking
Staring Spells	Strep Throat	Repetitive Movement	Tics (Motor)	Tics (Vocal)
Vomiting	Other:			

If endorsed, please explain: _____

_____

_____

When was your child toilet trained (age): Daytime: _____ Nighttime: _____

Historical or present concerns with occasional or excessive soiling or wetting during the day or night: (Yes) (No)

If yes, please explain: _____

_____

PSYCHIATRIC HISTORY

Has your child undergone a previous Psychological or Psychiatric evaluation: (Yes) (No) *If yes, please list below*

Have they been diagnosed with a mental health condition: (Yes) (No) *If yes, please indicate below*

ADHD	Anger Control	Anxiety Disorder	Asperger's Disorder	Autism Spectrum Disorder
Bipolar Disorder	Depression	Intellectual Delays	Learning Difficulties	Legal Problems
Neurological Illness	OCD	Personality Disorder	PTSD	Schizophrenia
Seizures	Substance Abuse	Suicidal Thinking	Trauma Conditions	Other:

Currently involved with any mental health services (i.e., psychotherapy, etc.): (Yes) (No) *If yes, please list below*

Provider Name: Date(s) Seen: Condition for Treatment:

_____

_____

_____

Known Trauma Experiences (*circle all that apply*)

Abuse (Emotional)	Abuse (Physical)	Abuse (Sexual)	Death of Loved One	Family Conflict
Marital Conflict	Substance Abuse	Suicide Attempt	Repeated Bullying	Other:

If endorsed, please explain: _____

_____

Immediate and Extended Family Mental Health Conditions (*circle all that apply*)

ADHD	Anger Control	Anxiety Disorder	Asperger's Disorder	Autism Spectrum Disorder
Bipolar Disorder	Depression	Intellectual Delays	Learning Difficulties	Legal Problems
Neurological Illness	OCD	Personality Disorder	PTSD	Schizophrenia
Seizures	Substance Abuse	Suicidal Thinking	Trauma Conditions	Other:

If endorsed, please explain: _____

_____

Anyone in the family that has similar concerns to your child: (Yes) (No) *If yes, please explain:* _____

_____

SOCIAL, EMOTIONAL, BEHAVIORAL HISTORY

Does your child make and maintain relationships: (Yes) (No) Do they have any close friendships: (Yes) (No)

Problematic Behaviors (*circle all that apply*)

Aggressiveness	Anxiety	Bullying Others	Being Bullied
Biting nails	Defiance/Oppositional	Depression	Difficulties Playing with Others
Elopement from Home	Immature Behavior	Explosive Emotions	Impulsivity
Interacting with Older Kids	Interacting with Peers	Interacting with Adults	Interacting with Family
Limited Attention	Limited Social Skills	Poor Empathy	Poor Eye Contact
Poor Transition Skills	Recognizing Humor	Peer Pressure	Thoughts of Self-harm
Rigid Thinking	Understanding Social Cues		Other:

If endorsed, please explain: _____

_____

_____

_____

EDUCATIONAL HISTORY

School: _____ Grade: _____ Have they been evaluated for special education: (Yes) (No)

If yes, was the evaluation within the last year: (Yes) (No) Does your child have: (IEP) (504 Plan) (Support Plan)

Educational placement: (General Education) (Gifted Education) (Special Education)

Has your child even been retained: (Yes) (No) Has your child been disciplined or suspended: (Yes) (No)

Present Academic Challenges (circle all that apply):

READING	WRITTEN EXPRESSION	MATHEMATICS	BEHAVIORAL
Comprehension	Capitalization	Aligning Numbers	Academic Anxiety
Sight Word Recognition	Idea Generation	Carrying/Regrouping	Attention/Distractibility
Skips Lines/Words	Grammar/Spelling	Multistep Problems	Emotional Outburst
Sounding out Words	Letter Reversals	Number Reversals	Impulsivity/Hyperactive
Speed (fast)	Punctuation	Recognizing Symbols	Social Adjustment
Speed (slow)	Structure/Legibility	Word Problems	Other:

If endorsed, please explain: _____

_____

_____

Teacher's report problems in: _____

_____

Historical Academic Challenges: _____

_____

Any behaviors you see from your child that teacher's don't at school: _____

_____

Teacher(s) name and email: _____

Please note that our evaluations often require additional information from the patient's teacher/instructor regarding social, emotional, and behavioral functioning in the educational setting. Please provide the patient's current teacher email below (if multiple teachers are involved, please provide at least two names/emails). We **will not send anything to the teacher prior to the evaluation date. On the day of the patient's evaluation, we will discuss what materials we are requesting teachers complete to facilitate this process and then forward that information to the teacher(s) provided below.*