611 W. Park Street, Urbana, IL 61801 | (217) 383-3311 | carle.org

Carle

Dear Parents,

Thank you for bringing your child to see us in the Developmental and Behavioral Pediatric Clinic at Carle on Curtis. Before your visit can be scheduled, we need the following returned:

- **The enclosed paperwork must be completed and returned.**
- **Individual Family Service Plan (IFSP) and Testing (if your child is receiving services through Child and Family Connections).**
- **Individual Education Plan (IEP) and Testing (if your child is getting special education through your local school)**

The information that you provide is essential to our visit. As you are waiting to see us, we have some general recommendations.

1. If your child is younger than three years old, and there are concerns about your child's development, please call your local Child & Family Connections Early Intervention Program at 800-323-4769 to find the number to call to schedule an evaluation. They will begin treatment services if a need is identified. This will make a huge difference for your child.

2. If you child is three to five years old, has developmental concerns, and is not yet in school, please contact the special education department at your local school district to ask for an Early Childhood Screening. The local school districts have excellent, free programs for preschool children with developmental disorders.

3. If your child is over one year old, we recommend that your child's doctor order a blood test called a ferritin level—a measure of total body iron. Iron is important for sleep, behavior and attention. If the level is below 40, then we recommend treatment with an iron supplement. Your child should be well for at least 2 weeks when the test is drawn or the level may be artificially high.

4. We recommend that all children take a daily multivitamin with iron (not a gummy type) unless you know your child should not take iron.

5. There is good evidence that the omega 3 fatty acid called DHA is important in brain development. Any child with a developmental concern should have this in their diet. It can be found in foods such as salmon, light tuna, some brands of eggs. It is also found in supplements. The suggested dose of DHA is approximately 150 mg per day.

We look forward to seeing you in our clinic!

Charles T. Morton, MD, FACP
Erica D. Wiebe, MD
Heather Ruthstrom, APRN

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DEVELOPMENTAL PEDIATRICS
NEW PATIENT QUESTIONNAIRE

Welcome! Please complete this form to help us understand your questions and concerns about your child. Thank you for your efforts-this will be helpful during your visit. If there are questions you aren't sure about, just do the best you can. Once you return this, we can schedule an appointment with one of our Developmental Pediatricians.

Today's Date:	Child's Birth Date:
Child's Name:	Nickname:
Your Name:	Relation to Patient:
Parent/Guardian:	2nd Parent/Guardian:
Relation to Patient:	Relation to Patient:
Address:	Address:
City/State/Zip Code:	City/State/Zip Code:
Phone: Home or Cell	Phone: Home or Cell
Current status of parents (check): ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Other:_____	
Child's Primary Care Provider and Practice Location:	
Child's Grade Level and School:	

Please return all evaluations with this paperwork. This is very important and will help us provide an accurate and appropriate evaluation for your child.

- ☐ Psychological evaluations
- ☐ Occupational, Physical, and Speech Therapy Evaluations
- ☐ School Testing
- ☐ Individual and Family Service Plans
- ☐ Individualized Education Plans (the current one as well as the ones that show all of the testing that has been done, often referred to as "eligibility")
- ☐ Medical Evaluations

REASONS FOR EVALUATION

Please list the problems, questions or concerns for which you want help for your child:_____

_____

_____

When did you first notice these problems?_____

_____

Please list any physicians who have treated your child in the past:_____

_____

_____

Regarding **SOCIAL SKILLS**, does your child:

	Yes	No	Comments:
Want to share with you when he/she enjoys something?			
Have back and forth conversations about all sorts of topics?			
Understand and care about other peoples' feelings?			
Make eye contact when appropriate?			
Seem to understand facial expressions?			
Use facial expressions to communicate feelings?			
Use and understand gestures in communication?			
Know how to interact with children his/her age?			
Enjoy playing with others vs. alone?			
Make and keep friends easily?			
Engage in imaginative pretend play?			

Regarding **BEHAVIOR**, does your child:

	Yes	No	Comments:
Have any repetitive motor movements (flapping, spinning, jerking)?			
Play repetitively with toys (lining up, spinning, flipping)			
Often repeat back what you have just said/asked rather than answering a question?			
Often repeat word for word dialogue from TV/ movies or something you have said in the past?			
Insist on sameness in routine?			
Have trouble switching activities?			
Have rituals that have to be done a particular way?			
Have a variety of interests that are typical for age?			
Have any obsessions or particularly intense interests?			
Seem hyperactive, inattentive, or impulsive compared to peers?			
Seem unusually oppositional or argumentative?			
Hurt themselves?			
Hurt other people?			
Worry a lot (about what?)			
Dangerous or unsafe behaviors?			
Have unusual responses to sensations?			

	Under-reacts	Over-reacts	Average
Texture			
Touch			
Noises			
Lights			

	Under-reacts	Over-reacts	Average
Tastes			
Smells			
Pain			
Other			

How often does your child have tantrums/meltdowns/outbursts?

☐ Daily ☐ Many times daily ☐ Weekly ☐ Rarely

What are the triggers?_____

_____

_____

How long do they last?_____

_____

What strategies have you tried?_____

_____

_____

DEVELOPMENTAL HISTORY

Has your child ever lost any skills? ☐ Yes ☐ No (If yes, please explain):_____

_____

_____

When did your child:

Sit on their own?_____ Walk alone?_____

Begin to use words like 'ball'?_____ Combine words (go out, want more)?_____

Was your child's development normal or delayed in the following areas?

Fine motor (picking up small objects, drawing or cutting) ☐ Normal ☐ Delayed

Personal-Social (playing with others, feeding and dressing self) ☐ Normal ☐ Delayed

If you feel your child has had developmental delays, please explain what they are:_____

_____

_____

These questions are about how your child is and has been most of his/her life.

Activity Level: ☐ Always moving and active ☐ Still and calm Sleep, appetite, bowels: ☐ Predictable ☐ Less Predictable Adaptation to changes in routine or daily activities: ☐ Flexible ☐ Inflexible React to new people or unfamiliar situations: ☐ Warms up with time ☐ Warms up quickly Sensitivity to: sounds, touch, clothing: ☐ Sensitive ☐ Less sensitive	Intensity of feelings or emotions (either positive or negative) ☐ Intense response ☐ More reserved response Distractibility ☐ Easily changes focus ☐ Pays attention Usual mood ☐ Pleasant and cheerful ☐ More critical/analytical Persistence ☐ Sticks with tasks/activities ☐ Moves on if tasks are difficult or frustrating

CURRENT ABILITIES/FUNCTIONING

What does your child do well? What do you love about your child?_____

_____

What do you and your child enjoy doing together?_____

_____

What chores or jobs does your child do at home?_____

_____

If you had to guess, what age child does your child most act like?_____

How would you rate your child's overall intelligence compared with others the same age?

☐ Below Average ☐ Average ☐ Above Average

Motor Skills: Are you concerned about your child's movement? ☐ Yes ☐ No

Please check specific concerns:

☐ Walking ☐ Throwing/Catching ☐ Running/Jumping ☐ Balance/Coordination

☐ Other:

Language: Are you concerned about your child's language? ☐ Yes ☐ No

Please check specific concerns:

☐ Understanding spoken directions ☐ Expressing him/herself verbally

☐ Speaking clearly ☐ Back and forth conversation skills

Fine motor and adaptive skills: Are you concerned about your child's ability to take care of him/herself and use his/her hands? ☐ Yes ☐ No

Please check specific concerns:

☐ Tying shoes ☐ Dressing ☐ Bathing/ self-hygiene ☐ Other:

Learning/Education: Are you or your child's teachers concerned about your child's ability to learn new information or to perform at school? ☐ Yes ☐ No

Please check specific concerns:

☐ Reading ☐ Spelling ☐ Math ☐ Handwriting ☐ Completing homework

☐ Study skills ☐ Organizational skills ☐ Failing grades ☐ Expulsion/suspension

☐ Trouble staying on task or paying attention

Do you or your child's teachers have any concerns about your child's behavior or social skills at school? ☐ Yes ☐ No

What is being done to work on learning, social, and behavior problems?_____

_____

_____

SCHOOL/THERAPY/SERVICES HISTORY

	OT	PT	Speech	Other
Ages received through early intervention				
Ages received in school				
Ages received privately				
Current providers				

Check if there is a current:

☐ Individual and Family Service Plan ☐ Individualized Education Plan ☐ 504 plan

Has your child had psycho-educational testing (IQ, achievement tests)? ☐ Yes ☐ No If yes, please include a copy.

If yes, when and by whom?_____

MEDICAL HISTORY

Early Medical History (Pregnancy, Birth, Infancy)

Pregnancy

Was there any difficulty getting pregnant or any fertility treatments? ☐ Yes ☐ No

- Please list the treatments used:_____

_____

_____

Number of prior pregnancies:_____

Mother's age during pregnancy:_____

Father's age during pregnancy:_____

When did prenatal care begin?_____

Was your child born earlier than 3 weeks before the due date? ☐ Yes ☐ No

If yes, how many weeks early?_____

Birth Weight :_____ Length:_____

How long did the mother stay in the hospital after birth?

_____

_____

How long did your baby stay in the hospital after birth?

_____

_____

Did your baby pass a newborn hearing test? ☐ Yes ☐ No

Was there a history of postpartum depression?

☐ Yes ☐ No ☐ Maybe, not officially diagnosed

What was your child like as a baby (easy to soothe, difficult to soothe, content, fussy, irritable, challenging, quiet…)

_____

_____

Yes	No	Pregnancy and Birth	Brief Description
		Illness	
		Medication taken	
		Low iron	
		Bleeding	
		Smoking	
		Alcohol or drug use	
		Trouble gaining weight	
		Vaginal delivery	
		Cesarean section	
		Prior miscarriage/abortion	
		Trouble during labor	
		Low apgar scores	
		Trouble with delivery	
		Trouble in the nursery	
		Home with mother	
		Neonatal Intensive Care	How long?

Childhood Medical History

Has your child had any chronic or severe illnesses or medical problems? ☐ Yes ☐ No

Please list and explain:_____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No

Please explain:_____

_____

Has your child ever had surgery? ☐ Yes ☐ No

Please explain:_____

_____

Allergies (medication, food, environmental, seasonal): ☐ No allergies ☐ Allergies to:_____

Are immunizations up to date? ☐ Yes ☐ No If no, why not?_____

Medications

1.	4.
2.	5.
3.	6.

Please list any alternative therapies, home remedies or dietary supplements you are using or have used in the past.

1.	4.
2.	5.
3.	6.

REVIEW OF SYSTEMS

Nutrition: Are you concerned about your child's eating habits or growth? ☐ Yes ☐ No
Please check specific concerns: ☐ Eats too much ☐ Eats too little ☐ Too picky ☐ Other:_____

Sleep: Does your child have any trouble with sleep? ☐ Yes ☐ No
What time does your child get in bed?_____ fall asleep?_____
Does your child move a lot during sleep? ☐ Yes ☐ No
Does your child wake up during the night? ☐ Yes ☐ No
Is there snoring? ☐ Yes ☐ No
Are there pauses in breathing? ☐ Yes ☐ No

Elimination: How often does your child have a bowel movement?_____
Is it: ☐ Too hard ☐ Too soft ☐ Average
Are there any accidents with stooling? ☐ Yes ☐ No

Does your child have any trouble with urination or bladder problems? ☐ Yes ☐ No
Please check specific concerns: ☐ Accidents during the day ☐ Accidents at night ☐ Other:_____

Does your child have (check if yes and please explain):
☐ Skin problems
☐ Birth marks
☐ Bone/muscle/joint problems
☐ Headaches
☐ Seizures
☐ Head too small/too big/odd shape?
☐ Vision/eye problems?
☐ Hearing/ear problems?
☐ Nose problems?
☐ Breathing problems (wheezing, cough or other)
☐ Neck Problems
☐ Stomach/Intestinal problems?
☐ Other:_____
☐ CHECK HERE IF YOUR CHILD HAS NONE OF THE PROBLEMS LISTED ABOVE

SOCIAL HISTORY

Have there been any stresses or family problems since your child was born (moves, marital conflicts, financial problems, etc.):

1._____

2._____

3._____

Who lives with the child at home? (Name, Age, Relationship):

1._____

2._____

3._____

4._____

5._____

Parents' Information	Child's Father	Child's Mother
Age		
Occupation		
Highest education or school grade completed		
Learning problems (specify)		
Behavior problems (specify)		
Medical problems (specify)		
Emotional problems (specify)		
Alcohol abuse		
Drug abuse		

Child's Brothers and Sisters

Name	Age	Briefly list any medical, behavioral or learning problems

FAMILY HISTORY

Please list any relatives on either side of the family who have the following.

Family History	Relationship to Child	Mother's Side	Father's Side
ADHD/Attention Deficit			
Anxiety/Panic			
Autism/Asperger's/PDD			
Bipolar Disorder			
Cancer			
Cerebral Palsy			
Child Abuse or neglect			
Coordination problems			
Death in the first year of life			
Depression			
Drug or alcohol abuse			
Eating disorder/Anorexia/Bulimia			
Genetic disorders			
Hearing problems/hearing loss			

Family History	Relationship to Child	Mother's Side	Father's Side
Heart problems in people younger than 45 years Heart Diagnosis:_____			
Intellectual disability/Mental disability			
Learning disability			
Mood disorder			
Muscle disorder			
Neurodegenerative disease			
Physical disabilities			
Schizophrenia			
Seizure or epilepsy			
Speech/Language problems			
Spinal cord problems			
Stroke			
Sudden death in people younger than 45 years Cause of death:_____			
Thyroid disease			
Tics or movement disorder			
Trouble walking			
Vision problems			
Has a relative had any of the following heart problems: Brugada syndrome, Wolff-Parkinson-White syndrome, hypertrophic cardiomyopathy, or prolonged QT syndrome?			

Is there anything else you would like to make sure we know about your child?_____