NorthShore
University HealthSystem

Evanston Hospital

Rebecca I. Nelson, Ph.D.
Department of Pediatrics
Developmental Follow-up Clinic

Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201

(847) 570-2208 tel
(847) 733-5057 fax

NORTHSHORE DEVELOPMENTAL FOLLOW-UP CLINIC
DEVELOPMENTAL HISTORY & QUESTIONNAIRE
0 - 5 Years of Age

Child's Name: _____ **M / F:** _____ **DOB:** _____

Today's Date: _____ **Referred by:** _____

You have requested an appointment with the Developmental Follow-up Clinic. Please complete the enclosed forms including the Developmental History Questionnaire, an insurance form, and authorization for release of information. Once your completed forms have been received, you will be contacted to schedule an in-person intake interview. Appointments for the evaluation sessions will also be scheduled at that time. Enclose or attach any relevant prior evaluations or therapy records to better understand your child. A copy of this completed form will be scanned into your child's permanent EPIC chart. Please attach a recent photo that can be kept in your child's file.

Return fax (847.733.5057) or mail this completed form to:

Rebecca Nelson, Ph.D. - Clinical Child Psychologist
NorthShore University HealthSystem
Dept. of Pediatrics, Division of Neonatology
Evanston Hospital, Developmental Follow-up Clinic
2650 Ridge Avenue, Room 1505
Evanston, IL 60201-1784

Mother(s) Name: _____ DOB: _____ Age: _____

Father(s) Name: _____ DOB: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ _____
(Mother) (Father)

Cell Phone: _____ _____
(Mother) (Father)

If parents are not living together, contact information of non-custodial parent:

_____

Pediatrician's Name & Business: _____

Address: _____ Phone: _____

Do you want a copy of the report sent to your pediatrician (circle one)? Yes No

Please briefly state the reason for requesting this evaluation and your expectations from it. Do you have concerns about your child? Has your pediatrician made any recommendations? Have teachers or daycare providers expressed concerns? _____

_____

_____

Child's school and grade/program: _____

_____

I - FAMILY HISTORY:

Is this child (circle one): biological adopted fostered stepchild

Marital Status (circle one): single married separated divorced

Has either the mother or father been married before? Yes _____ No _____

People living at home: _____

Sibling Name:_____ DOB: _____ Grade in school:_____
Sibling Name:_____ DOB: _____ Grade in school: _____
Sibling Name:_____ DOB: _____ Grade in school: _____

Step-Sibling Name:_____ DOB:_____ Grade in school: _____
Step-Sibling Name:_____ DOB:_____ Grade in school: _____

Do any of the siblings have any health or developmental concerns: If so, please describe: _____

_____

Language(s) spoken in the home: _____

Describe the child's relationship with other members of the family: _____

_____

Describe the marital relationship: _____

_____

II - PARENT INFORMATION:

Mother: Last grade completed: _____ Occupation: _____

Employed by: _____

Father: Last grade completed: _____ Occupation: _____

Employed by: _____

If both parents work outside the home, please describe childcare arrangements: _____

_____

Is there are any family history of developmental disability, autism, ADHD, psychological or psychiatric problems? If so, please describe: _____

_____

_____

III – PREGNANCY AND DELIVERY:

Number of previous pregnancies: _____ Miscarriages: _____ Abortions: _____

Is there a history of infertility? Yes _____ No _____ If yes, describe treatment: _____

_____

Was this a multiple birth? Yes _____ No _____

Describe any illnesses, conditions or accidents during the pregnancy (e.g., toxemia, excessive vomiting, viral infection): _____

_____

Medications (prescription and non prescription) taken during pregnancy: LIST: _____

_____

Consumed (circle all that apply): alcohol caffeine cigarettes illicit drugs

Ultrasound results (how many, when?): _____

Genetic testing? (results): _____

Birth (circle one): Hospital Home

Delivery Type: vaginal forceps assisted vaginal vacuum extraction Cesarean VBAC

Birth weight: _____ lbs. _____ ozs. # of weeks gestation: _____

Describe any complications during labor or delivery: _____

_____

APGAR scores: _____ 1 min. _____ 5 mins. _____ > 5 mins. _____

Infant's condition at birth: _____

Was your baby in an intensive care unit after birth? Yes _____ No _____ Length of Stay (days): _____

Describe ISCU/NICU Care (e.g., ventilation, seizures, feeding problems, infections, etc.): _____

Condition at discharge (circle all that apply): home monitor oxygen medications:

IV – MEDICAL HISTORY:

More than 3 ear infections each year (circle): Yes No

More than 6 respiratory infections each year (circle): Yes No

Emergency room visits (circle)? Yes No If yes, please describe: _____

_____

Hospitalizations (circle)? Yes No If yes, please describe: _____

_____

Please describe any other health issues for your child: _____

_____

V - GROWTH AND DEVELOPMENT: Please give the approximate age at which your child was first able to do each of the following. If not applicable (because of child's age) indicate with N.A.

Language/Communication:

Age
_____ Smiled socially
_____ Babbled
_____ Pointed meaningfully
_____ Spoke single words
_____ Spoke ≥ 2 word combinations
_____ Responded to own name
_____ Followed 1-step directions
_____ Identified body parts on self or others

Motor

Age
_____ Rolled over
_____ Sat without support
_____ Crawled
_____ Pulled to stand
_____ Walked independently
_____ Reached for toys
_____ Transferred toy hand to hand
_____ Scribbled
_____ Imitated scribbled shape, line
_____ Peddled a tricycle

Social Development:

Age
_____ Played/initiated games (e.g. peek-a-boo)
_____ In/out play (empty/fill containers)
_____ Play with cause/effect toys (e.g. pop up toys)
_____ Imitate actions
_____ Pretend play
_____ Help with dressing self
_____ Toilet trained

If you have concerns in the following areas, please describe:

Sleep: _____

_____

Feeding (breast/bottle/solids/eating): _____

_____

Gross or fine motor skills: _____

_____

_____

Speech and language: _____

_____

_____

Play (please include a description of what your child enjoys doing in his play): _____

_____

_____

Self help skills (e.g., feeding, dressing, etc.): _____

_____

_____

Child's age when concerning behaviors were first noticed: _____

_____

VI - PRIOR EVALUATIONS:

If your child was cared for in the ISCU at Evanston Hospital, but has never been seen in the ISCU Follow-up Clinic, or was seen more than one year ago, please describe why you are requesting this evaluation:
_____

If your child has had prior developmental and/or psychological testing, please describe: _____

_____

_____

PLEASE NOTE: We require that all children have a hearing test prior to, or scheduled in conjunction with, this evaluation. If available, a copy of the test results should be included with this form.

When was your child's last behavioral hearing exam: _____ Findings: _____

When was your child's last vision: _____ Findings: _____

Has your child been enrolled in any therapeutic intervention (physical, occupational, speech and language therapy, etc.) If yes, please describe: _____

_____

_____

VII - EARLY CHILDHOOD EDUCATION / PRESCHOOL:

Has your child been enrolled in daycare or preschool (circle one)? Yes No

If yes, name of school: _____ Age began: _____

Full time/part time: _____ Length of attendance (months or years): _____

Please describe what kind of an experience this has been for you and your child: _____
_____

VIII - ADDITIONAL INFORMATION:

If there is any additional information which you feel would help us know and understand your child better, please include here or attach separately: _____

_____

_____

Name of completing this questionnaire: _____

Relationship to child: _____