

**DEVELOPMENTAL FOLLOW-UP CLINIC
FAMILY AND DEVELOPMENTAL HISTORY
0 to 5 Years of Age**

Child's Name: _____ M/F: _____ DOB: _____
(please print)

Appointment Date: _____ Time: _____

You have requested an appointment with the Developmental Follow-up Clinic. Please complete the enclosed forms which include a developmental history questionnaire, an insurance form, and an authorization for release of information. Once your completed forms have been received, you will be contacted by one of our staff 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 that might be helpful in better understanding your child. Please attach a recent photo that can be kept in your child's file.

Please note: A copy of this completed form will be scanned into your child's permanent EPIC chart.

Joanne Bregman, Ph.D., Director
Rebecca Nelson, Ph.D.
NorthShore University HealthSystem
Evanston Hospital
ISCU Developmental Follow-up Clinic
2650 Ridge Avenue, Room 1505
Evanston, IL 60201-1784

Date: _____

Mother's Name: _____ DOB: _____ Age: _____

Father's Name: _____ DOB: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____
(Mother) (Father)

Work Phone: _____
(Mother) (Father)

Cell Phone: _____
(Mother) (Father)

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

Pediatrician's Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Do you want a copy of the report sent to your pediatrician? 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:

Referred by:

I - FAMILY HISTORY:

Is this child: biological, adopted, or fostered child? (circle one)

Marital Status: Single () Married () Separated () Divorced ()

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

People living at home:

Siblings:

Name: _____ DOB: _____ Grade in school: _____

Name: _____ DOB: _____ Grade in school: _____

Name: _____ DOB: _____ Grade in school: _____

Step-siblings:

Name: _____ DOB: _____ Grade in school: _____

Name: _____ DOB: _____ Grade in school: _____

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: _____

Current health status: _____

Father: Last grade completed: _____ Occupation: _____

Employed by: _____

Current health status: _____

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

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

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

Ultrasound results (how many, when?): _____

Genetic testing? (results): _____

Hospital of birth: _____ Home birth: _____

Type of delivery: vaginal _____ forceps assisted vaginal _____

Vacuum extraction _____ VBAC _____ Cesarean section _____ Induced _____

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

Describe any complications during labor or delivery:

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

Infant's condition at birth: _____

Was the baby in an intensive care unit after birth? Yes _____ no _____

Length of stay _____ If yes, please check and/or describe the following:

Respiratory distress _____ Number of days on ventilator _____

Number of days on oxygen _____ Seizures _____ Feeding problems _____

Infection _____ Brain bleed _____

Describe other complications: _____

Condition at discharge: _____ home monitor _____ oxygen _____ medications:

IV - MEDICAL HISTORY:

More than 3 ear infections each year: Yes _____ No _____ If yes, please describe:

More than 6 respiratory infections each year: Yes _____ No _____. If yes, please describe:

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

Hospitalizations? 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
- _____ Spoke using single words
- _____ Spoke using two or more word combinations
- _____ Responded to own name
- _____ Followed one step directions
- _____ Identified body parts on self, or others

Motor:

- _____ 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

Please describe each area in regard to concerns, patterns, or recent changes. If there are no concerns, that too should be indicated:

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.): _____

Developmental concerns - age when first noticed: _____

Behavioral/social concerns - age when 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.

Has your child had a hearing test? If yes, please describe:

Date of test: Type of test: (behavioral, OAE, BSAER)

Results:

Has your child had an eye exam? If yes, please describe:

Date: _____ Results: _____

Name of Physician/practice:

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

Has your child been enrolled in daycare or preschool? Yes _____ No _____

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

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:

VII - 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 person (and relationship to child) completing this questionnaire

INSURANCE INFORMATION

Please PRINT

Child's Name: _____ **DOB:** _____

Address: _____ **Home Phone:** _____

City _____, **State** _____ **Zip** _____

Mother's Name: _____ **DOB:** _____

Employer: _____

Business Address:

Soc. Sec #: _____ **Bus. Phone:** _____

Father's Name: _____ **DOB:** _____

Employer: _____

Business Address:

Soc. Sec #: _____ **Bus. Phone:** _____

PRIMARY INSURANCE (please complete)

Name of Insurance Company:

Claims Mailing Address: _____

City _____, **State** _____ **Zip code** _____

Insured/Policyholder: _____

Effective Date: _____ **ID/Policy #:** _____

Group #: _____