Child's Name: _____ M F Age: _____ Birth date: _____
Referred by: _____ Specialty: _____ Date: _____
Why do you want you child evaluated?_____

CURRENT CONCERNS ABOUT YOUR CHILD

Please check all that apply:

□ aggression
□ biting
□ hitting
□ overactivity
□ self-injury
□ temper tantrums
□ anxious
□ depressed
□ inattentive
□ language abilities
□ muscle tone
□ peer relationships
□ school environment
□ sleep problems
□ appetite/food selections
□ extended visual scrutiny
□ preoccupations
□ self-help skills
□ toilet training
□ motor skills
□ medication
□ self-stimulatory behaviors: rocking, spinning, flapping hands
□ Other:
_____

CHILD'S CURRENT LIVING SITUATION

With whom does the child currently reside? (please mark all that apply)

□ Biological Mother □ Step-mother □ Adoptive Mother □ Foster Mother
□ Biological Father □ Step-father □ Adoptive Father □ Foster Father
□ Other (describe: _____)

Complete the following for the child's BIOLOGICAL PARENTS to the best of your ability, *even if you are not the child's biological parent.*

Biological Mother's name: _____ Age: _____ Birth date: _____
Occupation: _____ Ethnic/Cultural Background: _____
Mobile Phone: _____ Home Phone:_____
Biological Father's name: _____ Age: _____ Birth date: _____
Occupation: _____ Ethnic/Cultural Background:_____
Mobile Phone: _____ Home Phone: _____

If the child currently resides with parents OTHER than biological parents, please describe them here:

Parent One's name: _____ Age: _____ Birthdate: _____
Relationship to child: □ Adoptive Parent □ Step-Parent □ Foster Parent □ Other:_____
Occupation: _____ Ethnic/Cultural Background: _____
Mobile Phone: _____ Home Phone:_____

Parent Two's name: _____ Age: _____ Birthdate: _____
Relationship to child: □ Adoptive Parent □ Step-Parent □ Foster Parent □ Other:_____
Occupation: _____ Ethnic/Cultural Background: _____
Mobile Phone: _____ Home Phone:_____

Highest level of education by each parent:

Biological Mother	Biological Father	Parent 1 (above, if app.)	Parent 2 (above, if app.)
□ 11th grade or less	□ 11th grade or less	□ 11th grade or less	□ 11th grade or less
□ GED	□ GED	□ GED	□ GED
□ High school grad.	□ High school grad.	□ High school grad.	□ High school grad.
□ Associates Degree	□ Associates Degree	□ Associates Degree	□ Associates Degree
□ Bachelor's Degree	□ Bachelor's Degree	□ Bachelor's Degree	□ Bachelor's Degree
□ Graduate/Professional	□ Graduate/Professional	□ Graduate/Professional	□ Graduate/Professional
□ Vocational Certificate	□ Vocational Certificate	□ Vocational Certificate	□ Vocational Certificate

If child does not live with BOTH biological parents, who has legal custody of the child? _____

How often does the other biological parent see this child? _____

Number of years married/together: _____ Approximate date of divorce/separation: _____

Number of times married: Mother _____ Father _____

If child is with ADOPTIVE parent, age child was first in home: _____ Date of legal adoption: _____

What has the child been told about the adoption? _____

If your child spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:

Name: _____ Age: _____ Birth date: _____

Relationship to child: _____ Ethnic/Cultural Background: _____

Occupation: Highest level of education: _____

Siblings: (please list whether the siblings live in the child's home or not)

Name of sibling	Birth Date	Sex	Full / Step / Half Sibling	Grade	In child's home?

Other occupants of child's residence NOT listed above: _____

What languages does the child use (List PRIMARY language first): _____

What other languages is your child exposed to? _____

HISTORY

Prenatal/Pregnancy

Did the biological mother have any of the following immediately before/after or during pregnancy?

Maternal injury. Describe: _____

Hospitalization during pregnancy. Reason: _____

X-rays during pregnancy. What month of pregnancy? _____

Did the biological mother have any of the following during pregnancy?

□ Emotional problems
□ Rashes
□ Difficulty in conception
□ Excessive swelling
□ Excessive nausea/vomiting
□ Kidney disease
□ Rh incompatibility
□ Urinary problems
□ Infections
□ Bed-rest
□ Anemia
□ Toxemia
□ Flu
□ Strep Throat
□ Headaches
□ Other virus
□ Premature Labor
□ Vaginal bleeding
□ Gained more than 35 pounds
□ Measles/German measles
□ High blood pressure
□ Threatened miscarriage
□ Severe cold
□ Airplane trip during pregnancy
□ Special diet, describe: _____
□ Other Complications:_____
□ Medications used during pregnancy: _____

Mother's age at conception: _____

Did the mother have previous pregnancies? □ No □ Yes, how many, including miscarriages? _____

Did mother receive prenatal care during this pregnancy? □ No □ Yes, beginning at month _____
During the pregnancy, was the baby: □ Very active □ Average □ Rather quiet
Were there any unusual changes in the baby's activity level during pregnancy? □ Yes □ No

Delivery

Was infant born full-term? □ Yes □ No
If premature, how early? _____ If overdue, how late? _____
Birth weight: _____ Apgars: at 1 minute _____ at 5 minutes _____
Type of anesthetic used: □ None □ Spinal □ Local □ General
Length of active labor: _____ Describe any complications during delivery: _____
_____
Check all of the following that applied to the delivery:

□ Spontaneous □ Breech □ Forceps □ Vacuum
□ Head first □ Multiple births □ Cord around neck
□ Induced; Reason: _____
□ Cesarean; Reason: _____

Which of the following applied to the infant? (check all that apply)

□ Breathing problems □ Required oxygen □ Required incubator
□ Feeding problems □ Sleeping problems □ Infection
□ Rash □ Excessive crying □ Bleeding into the brain
□ Seizures/convulsions □ Unusual appearance, describe: _____
□ Jaundice (Were bilirubin lights used? □ No □ Yes – How long? _____)

Did the infant require: □ X-Rays □ CT scans □ Blood transfusions
□ Placement in the NICU (If so, for how long? _____)
Length of stay in hospital: Mother _____ Infant _____

Developmental History

During this child's first three years, were any special problems noted in the following areas?

□ Irritability □ Breathing problems □ Colic
□ Difficulty sleeping □ Eating problems □ Temper tantrums
□ Failure to thrive □ Excessive crying □ Withdrawn behavior
□ Poor eye contact □ Early learning problems □ Destructive behavior
□ Convulsions/Seizures □ Twitching □ Unable to separate from parent
□ Other _____

Milestones. Indicate age when child:

_____ sat unaided _____ crawled _____ walked
_____ started solid foods _____ fed self with spoon _____ gave up bottle
_____ bladder trained – day _____ bladder trained – night _____ bowel trained
_____ rides tricycle _____ rides bike

Can child be described as clumsy/uncoordinated? □ Yes □ No Having fine motor delay? □ Yes □ No
Which hand does your child use for: Writing/drawing? ____ Eating? ____ Cutting? ____
Current eating behavior: □ Normal □ Picky □ Eats too much Amount of weight loss/gain _____
Oral Motor concerns □ None □ Drooling □ Gagging □ Difficulty swallowing

Language development

Indicate age when child begin babbling, such as repeating syllables, in attempts to communicate?:_____
using single words? _____ using phrases/short sentences? _____
Have there been any hearing concerns? □ No □ Yes Hearing testing – date? _____

Adaptive Skills

Feeds self	□ No	□ Yes, beginning at age _____
Dresses self	□ No	□ Yes, beginning at age _____
Bathes self	□ No	□ Yes, beginning at age _____
Helps with household chores	□ No	□ Yes, beginning at age _____
Knows phone number and address	□ No	□ Yes, beginning at age _____
Says "please" and "thank you"	□ No	□ Yes, beginning at age _____
Tells time accurately	□ No	□ Yes, beginning at age _____

Has the child ever lost skills, which at one time he/she was able to perform? □ No □ Yes

If yes, please explain _____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

□ Time out □ Physical punishment □ Yelling □ Loss of allowance/privileges
□ Ignoring □ Grounding □ Other, describe _____

Who is mainly in charge of discipline? _____

What do you find most difficult about raising your child? _____

_____

Family Changes and Stressors

Please indicate any major family stresses the family and/or child is currently experiencing or has experienced within the last year:

□ Marital discord/fighting □ Separation □ Divorce
□ Sibling conflict □ Parent-Child conflict □ Birth/Adoption of another child
□ Custody disagreement □ Single-parent family □ Parent/sibling death
□ Involved in juvenile court □ Parent deployed extensively □ Parent emotionally/mentally ill
□ Abandonment by parent □ Financial problems □ Parent substance abuse
□ Sexual abuse □ Physical abuse □ Parental disagreement about child-rearing
□ Child Neglect □ Involved with Social Services/Child Protective Services
□ Other, if not listed: _____

Please mark any of the following in each area that describe your child currently or in the past:

Speech

Past	Currently	Past	Currently
□	□ slow speech development	□	□ doesn't understand without gestures
□	□ unusual tone or pitch	□	□ repeats words/phrases over and over again
□	□ difficult to understand speech	□	□ repeats questions, instead of answering them
□	□ seldom speaks unless prompted	□	□ repeats dialogue from movies/songs verbatim
□	□ has language of his/her own (may sound like foreign language/jargon)		

Relating with other people

Past	Currently	Past	Currently
□	□ prefer to be by self	□	□ "in a world of his/her own"
□	□ aloof, distant	□	□ clings to people
□	□ fearful of strangers	□	□ not cuddly as baby
□	□ doesn't like to be held	□	□ doesn't recognize parent
□	□ fearful of strangers	□	□ doesn't play with other children
□	□ doesn't share achievements with you	□	□ doesn't do make believe play
□	□ has trouble understanding non-verbal hints like pointing or gestures		
□	□ prefers playing with younger or older children		

Imitation

Past	Currently
□	□ doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
□	□ doesn't repeat words/things said to him
□	□ doesn't repeat words generally, but usually did what he was asked to do

Response to Sounds, Speech

Past	Currently	Past	Currently
□	□ often ignores sounds	□	□ often ignores what is said to him/her (speech)
□	□ afraid of certain sounds	□	□ really likes certain sounds (music, motors,etc.)
□	□ doesn't respond to name being called		
□	□ seems to hear distant or soft sounds that most other people don't hear or notice		
□	□ unpredictable response to sounds (sometimes reacts, sometimes doesn't)		

Visual Response

Past	Currently	Past	Currently
□	□ stares vacantly around room	□	□ plays with turning lights on and off
□	□ often doesn't look at things	□	□ distracted by lights – stares at certain lights
□	□ likes to look at self in mirror	□	□ very interested in small parts of an object
□	□ likes to look at shiny objects	□	□ looks at things out of the corners of eyes
□	□ stares at parts of his/her body (e.g. hands)	□	□ doesn't respond to your pointing at objects
□	□ often avoids looking at people when they are talking to him		

Other Senses

Past	Currently	Past	Currently
□	□ puts many objects in mouth	□	□ likes vibrations
□	□ licks objects	□	□ doesn't notice pain as much as most people
□	□ overreacts to pain	□	□ smell objects unusual or unfamiliar objects
□	□ chew or eat objects that are not supposed to be eaten		

Emotional Responses

Past	Currently	Past	Currently
□	□ temper tantrums	□	□ laughs/smiles for no obvious reason
□	□ overly responds to situations	□	□ moods change quickly/for no apparent reason
□	□ often has blank expression on face	□	□ cries/seems sad for no obvious reason
□	□ little response to what is happening around him		

MEDICAL HISTORY

Has your child ever had:

□ Head injury Age _____ Describe _____

□ Loss of consciousness - Age ____ How long? _____ Describe_____

□ Allergies to food/medication List: _____

□ Surgery - Age_____ Reason _____ Describe_____

□ Ear Infections: Age ____ Describe _____

Is the child up to date on immunizations? □ Yes □ No, Why not? _____

_____

Doctors seen (check all that apply)

□ Pediatrician – Date of last visit: _____ Diagnosis: _____

□ Psychologist – Date: _____ Diagnosis: _____

□ Developmental Pediatrician – Date: _____ Diagnosis: _____

□ Neurologist – Date: _____ Diagnosis: _____

□ suspected seizures, describe: _____

□ seizures diagnosed, type: _____

□ Genetics – Date: _____ Diagnosis: _____

□ Psychiatry – Date: _____Diagnosis: _____

□ Gastroenterology – Date: _____ Diagnosis: _____

□ stomach/intestinal problems, type: _____

□ Endocrinology – Date: _____ Diagnosis: _____

Diagnostic Testing (check all that apply)

□ EEG (brain wave test) – Date: _____ Results: _____
□ MRI – Date: _____ Results: _____
□ CT Scan – Date: _____ Results: _____
□ Ophthalmology Evaluation – Date: _____ Results: _____
□ Chromosomal/DNA testing (Genetic) – Date: _____ Results: _____
□ Lead Level – Date: _____ Results: _____
□ Other - Describe: _____

Medication history

CURRENT medications – Include all supplements, vitamins, allergy medicines, etc.

Name of CURRENT Medicine taking	Dose and Frequency	Date Started	Reason Started	Effectiveness?

(PLEASE NOTE: DO ADMINISTER CHILD'S REGULARLY SCHEDULED MEDICATIONS, IF ANY, ON THE DAY OF YOUR APPOINTMENT.)

Who prescribes these medications? _____ Date of last visit: _____

PAST medications

Name of PAST Medicine taking	Dose and Frequency	Date Started	Date Ended	Reason Started and Ended	Effectiveness?

Who prescribed past medications? _____

FAMILY HISTORY

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply):

□ Birth Defect	□ Chromosomal/genetic disorder	□ Obsessive Compulsive Disorder
□ Cerebral Palsy	□ Severe head injury	□ High blood pressure
□ Kidney disease	□ Migraine headaches	□ Multiple Sclerosis
□ Physical handicap	□ Nervousness/Anxiety	□ Stroke
□ Tuberous Sclerosis	□ Alzheimer's disease	□ Hemophilia
□ Huntington's chorea	□ Muscular dystrophy	□ Parkinson's disease
□ Sickle-cell anemia	□ Cancer	□ Seizures/epilepsy
□ Diabetes	□ Heart disease	□ Food allergies
□ Alcohol/drug abuse	□ Depression	□ Physical/Sexual abuse
□ Schizophrenia	□ Mental Retardation	□ Speech/language delay
□ Autism/PDD	□ Reading problem	□ Other learning disability

□ Emotional disturbance/mental illness □ Bipolar/manic-depressive disorder

□ Tics/Tourette's syndrome □ Antisocial Behavior (assaults, thefts, arrests, etc.)

□ Childhood behavior disorder (aggressive/defiant/ADHD) □ Other: _____

Has anyone in the family ever received special education services? □ No □ Yes - for what reason?

_____

SCHOOL HISTORY

(If more space is necessary, please attach additional sheets or write on the back of this page.)

Current school: _____ School district: _____

Grade level: _____Type of class: □ Regular Ed □ Special Ed □ SDC □ RSP

Current # of: Students ____ Teachers ____ Aides ____ Does your child have a 1:1 Aide? _____

Has your child had special education testing in school? Please include if you had it performed privately also.

□ Psychological/Cognitive – Date: _____ Academic – Date: _____

□ Psycho-Educational Evaluation – Conclusions:_____

□ Speech/Language – Date: _____ Other: _____ Date: _____

Is your child receiving any special education services at school? □ Yes □ No

Is your child on an IEP (Individual Education Plan)? ____ For what reason? _____

Please list all of the schools, including preschools, your child has attended:

Name of School	Age	Grade	Hours per Day	Days per Week

SERVICES - Please list services your child has received.

School District (Please bring copies of your most recent Individual Education Plan (IEP))
Child's age when school services began: _____
Individual Education Plan (IEP) eligibility: _____
Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?

□ Speech therapy □ Occupational therapy □ Physical therapy
□ Adaptive Physical Education □ Discrete Trial Training (DTT/ABA) □ Social Skills
□ Other - describe:

Regional Early Intervention Services (i.e.,TEIS): (Please bring copies of your most recent assessment, Individual Family Service Plan (IFSP), Routines Based Interview (RBI), and relevant reports to your appointment.)
Is your child currently a client of the TEIS? □ Yes □ No
Child's age when regional services began: _____
Which services is your child CURRENTLY receiving through TEIS?
□ Speech therapy Provided by: _____ Age when began: _____
□ Occupational therapy Provided by: _____ Age when began: _____
□ Physical therapy Provided by: _____ Age when began: _____
□ Adaptive Physical Education Provided by: _____ Age when began: _____
□ Social Skills Provided by: _____ Age when began: _____
□ Discrete Trial Training (DTT/ABA) Provided by: _____ Age when began: _____
□ Other - describe: _____

Private Services (Please bring copies of relevant reports to your first appointment.)
Are you or your insurance companies currently paying for services to address your child's needs? □ Yes □ No
□ Speech therapy Provided by: _____ Age when began: _____
□ Occupational therapy Provided by: _____ Age when began: _____
□ Physical therapy Provided by: _____ Age when began: _____
□ Adaptive Physical Education Provided by: _____ Age when began: _____
□ Social Skills Provided by: _____ Age when began: _____
□ Discrete Trial Training (DTT/ABA) Provided by: _____ Age when began: _____
□ Other - describe: _____

Please SEND copies of your most recent Individual Education Plan (IEP), TEIS assessments or Individual Family Service Plan (IFSP) and any other relevant reports along with the completed appointment packet information to:

Pediatric Associates of Franklin
570 Bakers Bridge
Franklin, TN 37067

Appointment packets will be processed in the order received. You will receive written or telephone confirmation for receipt of the appointment packet. An appointment will be scheduled at that time. Thank you for trusting us with the care of your child and family.