NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Child Development Center
187 W. Schrock Rd.
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NationwideChildrens.org

Dear Parent/Guardian:

-Please complete this form prior to your appointment at Children's Hospital. It will provide us important information about your child so that we can assist you better. Please answer all the questions as completely as possible.

-Please be sure to bring any **previous evaluation reports**, such as school MFE/ETR and IEP, previous psychological evaluations, and any recent speech or occupational therapy evaluations to your appointment.

Today's Date: _____ Child's Name: _____

Date of Birth: _____ Child's Sex: ☐ Male ☐ Female

Mother's Name: _____ Father's Name: _____

Guardian's Name (if different than above) _____

Child's Social Security Number: _____

Home Address: _____
Street City State Zip County

Email Address: _____ Email Address: _____

Mother's Home #: _____ Father's Home #: _____

Mother's Cell #: _____ Father's Cell #: _____

Mother's Work #: _____ Father's Work #: _____

Person Completing this form _____ Relationship to Child _____

Child's Pediatrician: _____ Phone#: _____

Address: _____
Street City State Zip

Referral History:

1. Who referred your child to this clinic? _____
2. Why were you referred to this clinic? _____
3. Briefly describe the chief problems that are affecting your child and your family. _____

   _____
4. In what way are you hoping that we can be helpful with these problems? _____

   _____

5. Has your child ever been seen by a professional in the Nationwide Children's Hospital Behavioral Health or Child Development Center (includes psychologists, counselors, psychiatrists, developmental/behavioral pediatricians, Center for Autism Spectrum Disorders)? ☐ yes ☐ no

   If yes, by whom?
   _____

Services History:

1. Has your child received or is currently receiving any of the following services:

			Ages or Grades
Help Me Grow	☐ yes	☐ no	_____
Head Start	☐ yes	☐ no	_____
Speech/Language Therapy	☐ yes	☐ no	_____
Physical Therapy	☐ yes	☐ no	_____
Occupational Therapy	☐ yes	☐ no	_____
County Board of Developmental Disabilities	☐ yes	☐ no	_____
Learning Disabilities Tutoring	☐ yes	☐ no	_____
SSI/SSD	☐ yes	☐ no	_____

Others (e.g., types of therapy): _____

2. Has your child ever received any medical tests (e.g., EEG, MRI, genetics)? ☐ yes ☐ no
If yes, what were the tests and when did they occur? _____
_____

3. Has your child ever received a psychological evaluation (cognitive, academic, etc.)? ☐ yes ☐ no
If yes, who performed the evaluations and when did they occur? _____
_____

4. Has your child ever received an evaluation from a speech, occupational, or physical therapist? ☐ yes ☐ no
If yes, was it a school-based or private therapist and when did it occur? _____
_____

5. Has your child or your family ever been treated by a psychologist, psychiatrist, or counselor? ☐ yes ☐ no
If yes, please explain: _____
_____

Please bring a copy of the reports from previous evaluations discussed above.

Current Health Status:

Is your child taking any medications on a regular basis? ☐ yes ☐ no
If yes, please list medicines and reasons why child is taking them _____
_____

Is your child currently experiencing any pain? ☐ yes ☐ no
If yes, please explain _____

Are your child's immunizations up-to-date? ☐ yes ☐ no

Please list any current medical issues _____

Has your child ever engaged in the following? (check if yes)
Tobacco Use ___ Alcohol Use ___ Drug Use ___ Sexual Activity ___

Medical History:

Mother's age when child was born _____ Any previous miscarriages/stillbirths? ☐ yes ☐ no

Length of pregnancy/Age of gestation (weeks/months?) _____

Delivery was by: ☐ Vaginal birth ☐ C-section Was it a breech birth? ☐ yes ☐ no

Was labor induced? ☐ yes ☐ no Were forceps/vacuum extraction used? ☐ yes ☐ no

Length of labor _____ Child's birth weight _____ Child's birth length _____

Problems with delivery ☐ yes ☐ no (If yes, please describe; e.g., emergency C-section, slow heart rate, fever, cord around neck, toxemia, etc.) _____

Bleeding		Serious injury or illness		Had fever, rash, infection or other illness	
Gained 30 or more pounds		Alcohol Use		Had X-Rays	
Toxemia/High blood pressure		Drug use		Diabetes	
Took Prescription Medications (please list below)		Smoked cigarettes		Other (please describe below):	

Prescription Medications: _____

Other Comments: _____

Infant's Health at Delivery (check if yes)

Trouble breathing		Turned blue (cyanosis)		Needed oxygen	
Birth defects		Jittery			
Required any special care shortly after birth (please describe below)				How many days in the hospital? _____	

Special care after birth (e.g., blood transfusions, oxygen, incubator, medications, etc.): _____

_____

Other _____

Does your child have a history of any of these medical conditions? (check if yes)

Neurological problems		Hearing problems		Eye or vision problems	
Speech/language problems		Chronic Ear Infections		Hospitalizations	
Dental problems		PE Tubes		Surgery/Operations	
Sleep problems		Growth problems		Lead poisoning/Other poisoning	
Appetite, feeding, or nutritional problems		Sexual problems		Allergies	

If you checked yes to any of the above, please explain: _____

_____

_____

_____

Family History:

Which of the following racial backgrounds best describes… (place a check mark)	**Child**	**Mother**	**Father**
White, not of Hispanic origin			
African-American or Black, not of Hispanic origin			
Hispanic/Latino			
Native American Indian or Alaskan Native			
Asian, Asian-American, or Pacific Islander			
Other			

Does your child or family have any cultural or religions preferences or restrictions? ☐ yes ☐ no

If yes, please explain: _____

Please mark your religious affiliation		**Please mark any other relevant cultural background with which you identify**	
Catholic		Amish	
Jewish		Appalachian	
Jehovah Witness		Somalian	
Muslim		Other	
Protestant			
7th Day Adventist			
Latter Day Saints			
Other			

Predominant language spoken in your home:		Other languages spoken in the home (please list):	Would you like to have an interpreter at the visit? ☐ yes ☐ no
English			
Spanish			
Other (please list):			

Parents are:

Unmarried	☐ yes	☐ no	
Married	☐ yes	☐ no	Date: _____
Separated	☐ yes	☐ no	Date: _____
Divorced	☐ yes	☐ no	Date: _____
Widowed	☐ yes	☐ no	Date: _____

If parents are separated or divorced, who has legal custody? Mother Father Other

Please describe custody and visitation arrangements, including how often the child see the parent that s/he does not live with:

_____

_____

Is this child a foster child? ☐ yes ☐ no Is this child adopted? ☐ yes ☐ no

If yes, how long has the child been in your home? _____

Is this child aware that s/he is a foster or adopted child? ☐ yes ☐ no

If yes, please give as much information regarding biological parent(s) as you can:

_____

Mother's Name: _____ Age: _____

Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation: _____

Place of Employment: _____ Work Hours: _____

Father's Name: _____ Age:_____

Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation: _____

Place of Employment: _____ Work Hours: _____

Step-parent's name (if applicable):_____ Age:_____

Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation: _____

Place of Employment: _____ Work Hours: _____

- Who is living in the home at this time? (Please include everyone).

Name	Age	Relationship to Child
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

- Family members living outside of the home. (For example, a biological parent, brothers or sisters).

Name	Age	Relationship to Child
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

Problem Areas for Family Members:

Has anyone in your family experienced the following: Name/Relationship to Child:

ADHD (Attention Deficit/Hyperactivity Disorder)	☐ yes	☐ no	_____
Alcoholism	☐ yes	☐ no	_____
Anxiety	☐ yes	☐ no	_____
Autism Spectrum Disorder	☐ yes	☐ no	_____
Behavioral Problem	☐ yes	☐ no	_____
Depression	☐ yes	☐ no	_____
Drug Abuse	☐ yes	☐ no	_____
Dyslexia/Trouble learning to read	☐ yes	☐ no	_____
Intellectual Disability/Mental Retardation	☐ yes	☐ no	_____
Language Disorder/Speech Problem	☐ yes	☐ no	_____
Learning Disability/Held back in school	☐ yes	☐ no	_____
Manic Depression/Bipolar Disorder	☐ yes	☐ no	_____
Suicide or attempted suicide	☐ yes	☐ no	_____
Victim of Physical abuse	☐ yes	☐ no	_____
Victim of Sexual abuse	☐ yes	☐ no	_____
Seizures	☐ yes	☐ no	_____
Neurological disease/disorder	☐ yes	☐ no	_____
Genetic Disorder	☐ yes	☐ no	_____
Other health problems	☐ yes	☐ no	_____

Developmental History:

At what age did your child:

Sit without help?		Say single words meaningfully?	
Crawl?		Combine 2 or more words?	

Walk without help?		Use sentences?	
Walk up/down stairs?		Engage in conversation?	
Show a hand preference?			
Which hand?			

Is your child toilet trained? ☐ yes (Age completed: _____) ☐ no ☐ Started (Age: _____)

Does your child still experience toileting accidents during the: ☐ Day ☐ Night

Has your child experienced any of the following? (check if yes)

Language problems		Seems depressed		Social problems	
Fine motor problems (use of hands, writing, fasteners)		Seems anxious/nervous		Academic problems	
Gross motor problems (use of large muscles, clumsy)		Involved with Child Protective Services		Experienced a trauma (e.g., major accident, abuse)	
Problems with daily living skills (getting dressed, feeding self)		Involved in legal system		Behavior Problems (tantrums, aggression, defiance, etc.)	

Comment: _____

_____

_____

_____

_____

- Is your child involved in any activities outside of school where s/he can interact with peers (e.g., gymnastics, karate,
  girl scouts)? ☐ yes ☐ no Please list:
  _____
- Please list your child's strengths:
  _____
- Is your child experiencing any current stressors? ☐ yes ☐ no Explain:
  _____
- Has your child ever been employed? ☐ yes ☐ no Explain:
  _____

School History:

- Did your child attend preschool? ☐ yes ☐ no Age(s) of Attendance(s): _____
  Name(s) of Preschool: _____
- Age at Kindergarten entrance: _____ Age at First Grade entrance: _____ Current Grade: _____
- Current school's name and address: _____
- Has your child ever repeated a grade? ☐ yes ☐ no If yes, what grades? _____
- Has your child ever been placed in a special educational program? ☐ yes ☐ no
  Ages or Grades _____
  Please describe arrangement (teacher/aide-to-student ratio, time in mainstream classroom, etc.): _____
  _____
  _____

- Are there concerns about your child's ability to learn or with his/her behavior at school? ☐ yes ☐ no
  If yes, please explain. (i.e., What are the concerns, when did these concerns begin.) _____
  _____

Additional Information

Please add any additional information that you believe will help us to better understand your child.

_____
_____
_____
_____
_____

After your clinic visit, a report is written by the team members who evaluated your child. Please list below the telephone number and address of the person(s) to whom you would like the reports sent:

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Ph: _____ Ph: _____

Thank you for taking the time to complete this form. Please mail this back along with any additional paperwork and reports, including previous evaluations, IEP, MFE/ETR, etc. We are looking forward to meeting with you and your child.

Insurance Information

Nationwide Children's Hospital will contact your insurance company to pre-certify appointments and the following information is needed. You may write it down or send us a copy of the front and back of your insurance card. This does not guarantee insurance benefits for the appointment.

Name of the child receiving services: _____

Name of the insurance policy holder: _____

Name of the insurance company: _____

ID number: _____

Group number: _____

Pre-certification/Eligibility phone number: _____