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Child and Adolescent Medical Screening

PATIENT'S NAME

DATE of BIRTH

SOCIAL SECURITY #

NAME of PARENT(S)

ADDRESS

TELEPHONE: Home

Work

Fax

Email

Other Contact Information

Primary Care Physician

Specialty

Phone

Referring Psychiatrist/Psychologist

Specialty

Phone

CHIEF COMPLAINT (specify onset and duration)

MEDICATIONS (specify dosage, route, frequency, reason for prescription, and duration of treatment)

MEDICATION ALLERGIES

Gestational History

During this pregnancy, did the mother have ☐ anemia ☐ elevated blood pressure ☐ swollen ankles ☐ kidney disease

☐ heart disease ☐ bleeding ☐ measles ☐ German measles ☐ flu ☐ other virus ☐ vomiting ☐ injury

☐ medication during pregnancy ☐ emotional problems ☐ threatened miscarriage or early contractions

☐ other illness

Describe

In the 6 months preceding this pregnancy, did the mother have exposure to ☐ drugs or alcohol ☐ x-rays

Describe

Perinatal History

1. Where was the patient delivered?
2. What type of delivery was used?
3. What complications were encountered in the delivery?
4. What was the baby's birth weight?
5. What was the baby's condition at birth; what was the Apgar score?
6. What problems did the mother experience at delivery, or just afterwards?

Developmental History

1. When did the baby turn over?
2. When did the baby sit alone if place in this position?
3. When did the baby get to a sitting position unaided?
4. When did the baby crawl?
5. When did the child stand?
6. When did the child walk?
7. Did your child walk on his/her toes to a conspicuous degree, and does he/she still do this?
8. What other gait problems have been present?
9. When did your child feed him/herself with his/her fingers? with utensils? with a cup?
10. When did your child learn to undress him/herself? put on outer garments?
    manage buttons, zippers, and laces?
11. When was your child fully toilet trained (bladder and bowl, day and night)?
12. What difficulties were encountered in these areas of training?
13. When did your child use single words? phrases? sentences?
14. How clear or well-formed was speech, and how is it presently utilized? Is it meaningful speech?

<u>Development relative to peers:</u>

Gross Motor Skills	*Normal Progress*	*Lagging Behind*	*Loss of Prior Skill*
Fine Motor Skills	*Normal Progress*	*Lagging Behind*	*Loss of Prior Skill*
Handwriting	*Normal Progress*	*Lagging Behind*	*Loss of Prior Skill*
Intellect	*Normal Progress*	*Lagging Behind*	*Loss of Prior Skill*
Language	*Normal Progress*	*Lagging Behind*	*Loss of Prior Skill*
School Performance	*Normal Progress*	*Lagging Behind*	*Loss of Prior Skill*

Immunizations current?

Polio ☐ Date: ______ Rubeola ☐ Date: ______

Rubella ☐ Date: ______ DPT ☐ Date: ______

Past Medical History

Has your child ever been hospitalized? When and for what reasons?

Doctor:

What feeding problems were encountered in the past?

Did the baby have colic? ◯ *No* ◯ *Yes*

Have there been any intestinal problems? ◯ *No* ◯ *Yes*

Chronic diarrhea? ◯ *No* ◯ *Yes*

Constipation? ◯ *No* ◯ *Yes*

Fecal retention? ◯ *No* ◯ *Yes*

Fecal soiling? ◯ *No* ◯ *Yes*

Please explain:

Have there been any significant injuries, illnesses or operations? ◯ *No* ◯ *Yes (explain)*

How did the child sleep, and what problems are now evident?

Does hearing seem adequate by the parents' standards? ◯ *No* ◯ *Yes*

Has anyone else questioned the patient's hearing ability? ◯ *No* ◯ *Yes*

Has there been any illness involving the ears? ◯ *No* ◯ *Yes*

What eye problems has the child had?

Has the patient used glasses? ◯ *No* ◯ *Yes* Has there been any strabismus? ◯ *No* ◯ *Yes*

Has there been any eye therapy? ◯ *No* ◯ *Yes*

Has the patient experienced any seizures, with or without fever? ◯ *No* ◯ *Yes*

Have there been any trance-like episodes or minor lapses which could be petit mal or other seizure fragments? ◯ *No* ◯ *Yes*

Has the child been excited by medications which would normally be sedative in nature or without anticipated psychotropic effect? ◯ *No* ◯ *Yes*

Has there been excessive urination? ◯ *No* ◯ *Yes* excessive fluid intake? ◯ *No* ◯ *Yes*

bed wetting? ◯ *No* ◯ *Yes* urinary tract infection? ◯ *No* ◯ *Yes*

What neurological complaints are present, such as headache, vomiting, poor balance, double vision, dizziness, weakness, numbness, etc.?

Have there been severe or repeated blows to the head? ◯ *No* ◯ *Yes*

Girls: Age of onset of menses ______ Is menstruation regular? ◯ *No* ◯ *Yes*

Family History of

- ☐ Learning problems or behavioral disturbances
- ☐ Abortions (2 for any one mother)
- ☐ Stillbirths
- ☐ Congenital anomalies
- ☐ Mental retardation
- ☐ Neurological disorders
- ☐ Other (list)

Physical Features

Height ______ Weight ______

Normal growth rate this past year? Height ◯ *No* ◯ *Yes* Weight ◯ *No* ◯ *Yes*

Blood pressure ◯ *normal* ◯ *high* ◯ *low*

NAME OF PARENT ______

Relationship to patient ______

SIGNATURE ______ **DATE** ______

Comments