Pediatric Specialty Services - Developmental Program

5339 N. Interstate 35 Frontage Rd Suite #100
Austin, TX 78723
Office Phone 512-324-0098
Fax 512-380-4274

Purpose
The Pediatric Developmental Program provides diagnostic evaluations, developmental monitoring and medical follow-up for children with developmental and behavioral disorders. We see children for developmental delay, speech/language impairments, ADHD, autism, Down's Syndrome, and NICU graduates. Standardized diagnostic tests are used to assess developmental needs. We do NOT perform testing for children over 5 years of age.

Location:
We are located at the Specially for Children building off of Interstate 35 Frontage Rd. in between Auto Zone and Walgreens.

Scheduling/Contact:
For appointments and general questions regarding the program, call 512-324-0098. New patient appointments require referrals through primary care provider stating reason for referral or consultation. New patient paperwork is available at the www.speciallyforchildren.com website. Select specialty tab, go to Developmental Pediatrics and select patient forms. We ask that forms be completed and insurance authorization obtained prior to scheduling any new appointment. We encourage you to contact your insurance company to verify your benefits. Your new patient packet can be emailed to namendoza@seton.org

Team Members
Board Certified Developmental-Behavioral Pediatrician
Pediatric nurse Practitioner
Pediatric Residents
Registered Nurse
Physical Therapist
Occupational Therapist
Speech Therapist

The Evaluation:
Evaluations usually involve 2-3 visits. The first visit will be an initial consult by the developmental-behavioral pediatrician or nurse practitioner who will review the child's developmental and medical history and perform a comprehensive physical exam and developmental screening. Some children will be referred for further testing and/or evaluations by speech, occupational, physical therapist and/or other member of the team . Results of testing as well as treatment recommendations are shared with parents on a follow-up visit.

What You Need To Bring:
A picture of your child in his/her "normal" setting (please be sure your child is the *only* one in the picture). The appointments can take 1-2 hours so bring your child's favorite toys, snacks or any items that may help him/her be more comfortable for the visit. Outside therapy, educational or medical records should be brought to visit and faxed to 512-380-4274 BEFORE the day of the appointment.

CHILD'S NAME: _____DATE OF BIRTH: _____ AGE: _____
PERSON COMPLETING FORM: _____DATE FORM COMPLETED: _____
CHILD'S PRIMARY CARE PROVIDER: _____

LIST CONCERNS ABOUT YOUR CHILD'S HEALTH, DEVELOPMENT and BEHAVIOR: please use extra space on the last page if needed

_____
_____
_____
_____

Please share with us what you hope to get from your visit: please use extra space on the last page if needed

_____
_____
_____
_____

PREGNANCY & BIRTH please use extra space on the last page if needed
Is the child yours by: ❑ birth ❑ adoption ❑ stepchild ❑ other: _____
Birthplace _____ Please list any medical problems during your pregnancy ❑ none ❑ other:

_____
_____
_____

Delivery by ❑ vaginal birth ❑ Caesarian If Caesarian, why? _____
Birth weight: _____ Birth length: _____ APGAR score (if known) 1 min____ 5 min.____
Please indicate any medical problems during the baby's newborn period ❑ **none**
If premature, how early?_____ Other problems: _____

_____
_____

NUTRITION & FEEDING please use extra space on the last page if needed
How was/is your infant fed? ❑ bottle fed ❑ breastfed how long? _____
Milk intake now: Type ❑ cow milk (❑ skim ❑ 1% fat ❑ 2% fat ❑ whole milk) ❑ soy milk ❑ rice milk
Average ounces per day (Note: 8 ounces are in 1 cup)_____ ❑ uses a bottle ❑ uses a cup
Juice intake: ❑ none Average ounces per day_____
On a special diet? ❑ **No** ❑ **Yes** If yes, please explain: _____
Has your child had any unusual feeding/dietary problems? ❑ **No** ❑ **Yes** If yes, please explain: _____

_____
_____

SLEEP please use extra space on the last page if needed
Bedtime _____ Hours per night_____ Naps (number & length) _____
Any sleep problems? _____

_____

DEVELOPMENT please use extra space on the last page if needed
At what age did your child: sit alone_____ walk alone_____ say words_____ toilet train _____
If you are concerned about your child's development, at what age did you begin to worry?_____
IMMUNIZATIONS/INFECTIOUS DISEASES: *Please bring your child's shot record to your appointment.*
Has your child had: ❑ chickenpox ❑ measles ❑ mumps ❑ rubella ❑ meningitis ❑ tuberculosis (TB)
ALLERGIES TO MEDICINES: ❑ none ❑ other_____
MEDICINES/VITAMINS: ❑ none ❑ other _____

_____
_____

DENTAL HISTORY
Has your child seen a dentist? ❑ **No** ❑ **Yes** If so, how often _____ Last visit _____

EXPOSURES/HABITS
Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ **No** ❑ **Yes**
Is your child exposed to cigarette smoke? ❑ **No** ❑ **Yes**
TV—hours per day_____ Computer—hours per day_____ Video games—hours per day_____

PAST MEDICAL HISTORY please use extra space on the last page if needed
Please describe any major medical problems and their dates or age they began:
_____
_____
_____
_____
Hospitalizations/Operations/Serious accidents/Head injury/Concussion/Loss of consciousness (with dates):
_____
_____
_____

REVIEW OF ORGAN SYSTEMS
Please write in any symptoms not listed here in the blank boxes
❑ **Check this box** if your child has **NONE** of the following problems

General	**Muscles / Joints/ Bones**	**Neurological**
❑ Fevers ❑ chills ❑ excessive sweating	❑ Muscle aches ❑ joint pain	❑ Headaches
❑ Unexplained weight loss or ❑ gain	❑ Leg aches	❑ Weakness
Ears / Nose / Throat	**Allergy**	❑ Clumsiness
❑ Unusually loud voice ❑ hard of hearing	❑ Hayfever ❑ itchy eyes	❑ Staring spells ❑ seizures
❑ Mouth breathing ❑ snoring	**Skin**	**Emotional / Behavioral**
❑ Bad breath	❑ Rashes	❑ Speech problems
❑ Frequent runny or stuffy nose	❑ Areas with unusual color	❑ Anxiety ❑ stress
❑ Frequent ear infections	❑ birthmarks	❑ Problems with sleep ❑ nightmares
❑ Problems with teeth/ gums	**Blood /Glands**	❑ Depression
Eyes	❑ Unexplained lumps	❑ Nail biting ❑ thumb sucking
❑ Squinting ❑ "crossed" eyes	❑ Easy bruising ❑ bleeding	❑ Bad temper ❑ breath holding
Breathing	❑ Fainting	❑ jealousy
❑ Cough ❑ wheeze	**Genitourinary**	❑ talks back too often
Heart	❑ Bedwetting	❑ always on the go
❑ Tires quickly with exertion or feeding	❑ Pain with urination	❑ decreased attention level for age
❑ Shortness of breath	❑ Unusual odor or color of urine	
Digestive system	❑ Discharge: penis or vagina	
❑ Nausea ❑ vomiting ❑ diarrhea		
❑ Constipation		
❑ Blood in bowel movement		

FAMILY HISTORY
Please use the initials listed below to indicate anyone who has/had the condition:

M-Mother	F-Father	B-Brother	S-Sister	MA-Maternal aunt	PA-Paternal aunt
MGM-Maternal grandmother	PGM-Paternal grandmother			MU-Maternal uncle	PU- Uncle
MGF-Maternal grandfather	PGF-Paternal grandfather			MC-Maternal cousin	PC-Paternal cousin

Genetic disease_____	Kidney disease_____	Depression / Anxiety_____
Birth defects_____	Heart disease or stroke before 60_____	Alcoholism / drug use_____
Prematurity_____	High blood pressure_____	Thyroid disease_____
Lost pregnancies_____	Bleeding / Clotting problems_____	Seizures / Tics_____
Reading problems_____	Asthma / Hay fever / Eczema_____	ADHD (attention problems)____
Slow learning_____	Cancer / Diabetes_____	Hearing loss / Vision loss_____

SOCIAL HISTORY

Who lives at home?

Name Age Relationship Highest Education level

_____

_____

_____

_____

_____

_____

Parents are: ❑ married ❑ not married ❑ separated—since: _____ ❑ divorced—since: _____

Parents' employment: Mother _____ Father _____

Is violence at home a concern? ❑ **No** ❑ **Yes** Are there guns in the home? ❑ **No** ❑ **Yes**

Child care situation ❑ parents ❑ others (specify who and hours per day) _____

_____

If your child is old enough to do extracurricular activities or sports, please list them: _____

_____

_____

BEHAVIORAL and SCHOOL HISTORY

Was/Is your child :	**During the first 12 months?**		**Now?**	
	Yes	No	Yes	No
Colicky			N/A	
Difficult to feed				
Difficult to get to sleep				
Difficult to put on a schedule				
Alert				
Easy to comfort				
Affectionate				
Difficult to keep busy				
Cheerful				
Overactive, in constant motion				
Very stubborn, challenging				
Irritable or grouchy				
Sociable				

Did/does your child attend occupational, physical or speech therapy? ❑ **No** ❑ **Yes** ❑ **OT** ❑ **PT** ❑ **ST**

For each grade your child has been in, beginning with preschool, please tell us the school attended and whether she or he had any learning or behavioral problems that year.

School **Age or grade** **Special classes** **Learning or behavioral problems**

_____

_____

_____

_____

_____

_____

Any concerns about current school performance? ❑ **N/A** ❑ **No** ❑ **Yes** _____

Any concerns about relationships with: Teachers ❑ **N/A** ❑ **No** ❑ **Yes**_____

Students ❑ **N/A** ❑ **No** ❑ **Yes**_____

If over 4 years old, does your child have a best friend? ❑ **No** ❑ **Yes**

BEHAVIORAL HISTORY continued

What prompted you to seek an evaluation of your child's behavior *at this time*?

How have you tried to manage your child's behavior, especially when it is a problem for you?

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

If these methods do not work and the problem behavior continues, what are you likely to do then to cope with your child's misbehavior? _____

Are you and your spouse (or partner) consistent in managing your child's behavior? ❑ **No** ❑ **Yes** If no, please explain: _____

Are your beliefs about discipline consistent with your spouse or partner's? ❑ **No** ❑ **Yes** If no, please explain:

What qualities does your child have that you particularly enjoy?_____

What do you consider to be your child's strongest or best points?_____

Has your child ever been evaluated previously for developmental, behavioral, or learning problems? ❑ No ❑ Yes

If so, when, who provided the evaluation, what type of evaluation did the child have, and what were you told about your child regarding the results of any evaluations?

_____
_____
_____
_____
_____
_____

Has your child ever been seen or treated by a neurologist? ❑ No ❑ Yes

If so, when, who was the doctor, what tests (EEG's, brain scans) were done, and what medications if any were prescribed?

_____
_____
_____
_____
_____
_____

Has your child ever received any psychiatric or psychological treatment? ❑ No ❑ Yes

If so, what type of treatment did she/he receive and how long did the treatment last? Who provided this treatment to your child?

_____
_____
_____
_____
_____
_____

Has your child every received *medication* for behavior or emotional problems? ❑ No ❑ Yes

If so, who was the doctor, what type of medication did your child take, at what dose, and for how long?

_____
_____
_____
_____
_____
_____

Please use this page if you need to provide any further information that was not discussed above or if you need more room to complete any answers.