Intensive Pediatric Evaluation

Patient name:

Date of birth:

Today's date:

COMPLETE THIS SECTION ONLY IF THE PURPOSE OF THE VISIT IS AN INTENSIVE PEDIATRIC EVALUATION.

Physical Stressors

Were there any significant falls or traumas to the mother during the pregnancy?

○ Yes ○ No ○ Unsure

List any evidence of birth trauma:

- ☐ Bruising
- ☐ Respiratory depression
- ☐ Cord around neck
- ☐ Stuck in birth canal
- ☐ Fast or excessively slow birth
- ☐ Unknown/unsure
- ☐ None
- ☐ OTHER
- ☐ Odd-shaped head

Does the child have any history of serious falls or injuries, including fractures, concussions, hospitalizations, etc.?

○ Yes ○ No ○ Unsure

Does the child wear a backpack? _____
Does child participate in sports or exercise activities? _____
Does child engage in any hobbies or activities which require prolonged, awkward or repetitive postures (violin, gymnastics, ballet, etc.)?

Yes No Unsure OTHER

Chemical Stressors

As an infant, was the child breastfed? _____
Was formula introduced? _____
Was cow's milk introduced? _____
Have solid foods been introduced? _____
Does the child have any food, liquid or juice intolerances or allergies?

Yes No Unsure OTHER

During the pregnancy, did the mother smoke?

Yes No Unsure

During the pregnancy, did the mother drink alcohol?

Yes No Unsure

During the pregnancy, did the mother use recreational drugs?

Yes No Unsure

Did the mother suffer any illnesses during the pregnancy?

Yes No Unsure OTHER

Were any nutritional supplements prescribed or taken during the pregnancy?

Yes No Unsure

Were ultrasound(s) performed during the pregnancy?

Yes No Unsure

Were any invasive procedures performed during the pregnancy (Amniocentesis, Cerclage, etc.)?

Yes No Unsure

Are there any pets in the child's home?

Yes No Unsure

Are there any smokers in the child's home or environment?

Yes No Unsure

Has the child had any adverse reactions to vaccinations or medicines?

Yes No Unsure

Is there any history of antibiotics given to the child?

Yes No Unsure

Psychosocial Stressors

Have there been any difficulties with child-parent bonding?

Yes No Unsure

Does the child have any behavioral problems?

Yes No Unsure

Have any of the following behaviors occurred? Check all that apply.

- Attention issues
- Night terrors
- Bedwetting
- Sleepwalking
- Difficulty sleeping
- Stutter or stammer
- Failure to maintain eye contact
- Unsure
- Hearing issues
- OTHER
- Nervous tics

On average, how many hours per week of television does the child watch?

Do you feel the child's social and emotional development is normal for their age?

Yes No Unsure

Was there any delay in terms of the child's achievement of developmental goals? Choose all that apply.

- None, all developmental goals were met on schedule
- Delayed response to sound
- Delayed normal appearance of teeth
- Delayed ability to follow an object
- Delayed ability to crawl
- Delayed ability to hold head up
- Delayed ability to walk
- Delayed ability to vocalize
- Unsure
- Delayed ability to sit alone
- OTHER