



**CHILD DEVELOPMENT CENTER
CHILDHOOD HISTORY FORM**

Patient Information		
Last Name:	First Name:	DOB:
SS#:	Sex: Male/Female:	
Street Address:	Race:	Religion:
City	State:	Zip Code:
County:	Home Phone:	
Primary Care Physician Name:	PCP Phone Number:	
Primary Care Physician Address:		
Parent/Guardian Information		
Father/ other	DOB:	SS#
Last Name:	First Name:	
Street Address:	City:	
State:	Zip Code:	Home Phone:
Occupation:	Work Phone:	
Employer's Name and Address:		
Mother/other	DOB:	SS#
Last Name:	First Name:	
Street Address:	City:	
State:	Zip Code:	Home Phone:
Occupation:	Work Phone:	
Employer's Name and Address:		
Emergency Contact Name & Phone Number		

Primary Insurance	
Insurance Company Name:	
Billing Address	
City:	State: Zip Code:
Insured's Name:	Policy Number:
Group Number:	Phone Number:
Secondary Insurance	
Insurance Company Name:	
Billing Address	
City:	State: Zip Code:
Insured's Name:	Policy Number:
Group Number:	Phone Number:

I authorize release of medical information necessary to process insurance claim(s): I authorize and direct my insurance carrier or it's intermediaries to issue payment check(s) directly to Morristown Memorial Hospital, Atlantic Health and agents and/or intermediaries for services rendered.

I understand that I am responsible for any amounts not covered by my insurance. Further I understand that your office cannot accept responsibility for collection my claim or for negotiating a settlement on a disputed claim. I am responsible for payment of my account within the limits of our credit policy

Signed: _____ **Date:** _____

CHILDHOOD HISTORY FORM

Today's Date _____

Child's Name (First, Middle, Last)

Child's Date of Birth _____

Preferred Name or Nick-Name _____ Age _____

If we may contact you by email please provide email address: _____

Cell Phone Contact _____

Child is presently living with:

Biological Mother _____

Biological Father _____

Adoptive Mother _____

Adoptive Father _____

Stepmother _____

Stepfather _____

Foster Mother _____

Foster Father _____

Other (specify): _____

Primary language in home _____ Secondary language in home _____

Child's School (name/town) _____

Grade _____ Special Placement (if any) _____

Who referred you for this evaluation?

What specific questions would you like answered by this evaluation?

1. _____
2. _____ 3. _____

Is your child receiving care from a day care center or childcare provider? _____ # of days _____

Name of Provider/Center: _____

Check off any concerns in the following areas:

Behavior problems at home	_____	Hyperactivity	_____
Behavior problems at school	_____	Attention span/Distractibility	_____
Reading problems	_____	Speech/language problems	_____
Math problems	_____	Developmental delay	_____
Problems-all school subjects	_____	Other	_____

List names and addresses of pediatrician and other professionals involved with the child (Specialist, counselor, etc.)

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Conditions being treated</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

PREGRANCY/ (IF CHILD IS ADOPTED THEN FILL OUT ALL KNOWN INFORMATION)

Number of pregnancies: _____ Miscarriages/Abortions: _____

Mother's age at time of delivery _____ Birth weight _____

Was Child Full Term/ What Gestation _____

Hospital/Location _____

Complications and Medical Problems of Mother: (Infections; Hypertension; Toxemia; Exposures to Toxins; Hospitalizations; Bleeding)

Medical Tests: (Amniocentesis, Other)

List all the medications (prescribed or over-the-counter) that were taken while pregnant:

Smoking during pregnancy _____ #cigarettes per day _____

Alcohol/Other Drug use (specify) _____ frequency _____

Psychological problems _____

DELIVERY

Type of Labor: Spontaneous _____ Induced _____ Duration (hrs) _____

Type of Delivery: Normal _____ Breech _____ Caesarian _____

Reason for Caesarian: fetal distress _____ Repeat _____

Complications at Delivery: _____

Apgar Scores _____

POST DELIVERY PERIOD

Number of days infant was in the hospital after delivery _____

Respiratory Distress (specify # of days for oxygen or ventilation) _____

Infection (specify) _____

Jaundice _____ Treated by lights (phototherapy) _____

Was hearing screening normal? _____ Eye problems _____

Other (e.g. seizures, heart problems, operations, feeding by tube, head bleed)

INFANCY PERIOD

Did your child exhibit any of the following, to a significant degree, during the first few years of life? If so, describe: _____

Did not enjoy cuddling _____

Difficult to comfort _____

Excessive restlessness _____

Colic _____

Excessive irritability _____

Diminished sleep _____

Frequent headbanging _____

Difficult nursing _____

Constantly into everything _____

Other(specify) _____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood illness _____

Hospitalizations _____

Operations _____

Head injuries _____

Convulsions _____ with fever _____ without fever _____

Eye problems _____

Ear problems _____

Wheezing _____

Allergies _____

Poisoning _____

Appetite/bowels _____

Sleep problems _____

PRESENT MEDICAL STATUS

Height _____ Weight _____

Present illness for which your child is being treated _____

Medications or supplements child is taking on ongoing basis _____

Are immunizations up to date? Yes No _____

If No, please explain _____

Has your child been seen by an Eye Doctor?

Yes ___ No ___ Results _____

DEVELOPMENTAL MILESTONES

	Note the age or:	Early	Normal	Late
Smiled				
Sat without support				
Rolled				
Walked without assistance				
Waiving Bye-Bye				
Pointing				
Said mama/dada				
Spoke first words				
Said 2-word				
Said 3-word phrases				
Began saying sentences				
Bladder trained, day				
Bladder trained, night				
Bowel trained, day				
Bowel trained, night				
Rode tricycle				
Rode bicycle (no training wheels)				
Buttoned clothing				
Tied shoelaces				
Named colors				
Named coins				
Said alphabet in order				
Began to read				

COMMUNICATION

In your opinion, was the rate of language development:
average _____ slow _____ interrupted _____

Have you ever questioned your child's hearing ability?

Does child use extensive gestures instead of words?

Does child avoid speaking? _____ recognize own difficulty? _____

If applicable, when speech difficulty was first noticed _____

By whom _____

What changes have been noticed in child's speech since the difficulty was noticed?

How do people react to child's problem?

What has helped child develop better speech?

Give examples of child's present speech:

What percent of child's speech is understood by familiar listeners _____ unfamiliar _____?

COORDINATION

Approximately rate your child on the following skills with a check mark:

	Above Average	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			
Excessive number of accidents compared to other children (specify)			

COMPREHENSION AND UNDERSTANDING

Do you think your child understands directions and situations as well as other children his or her age? Yes ___ No ___ If not, to what do you attribute this?

How would you rate your child's overall level of intelligence compared to other children?

Below average Average Above Average

Has your child ever had to repeat a grade? If so, when?

Present class placement: Regular Class Special Class (if so, specify)

Kinds of special counseling or remedial work your child is currently receiving

Is your child currently classified or receiving 504 accommodations?

Explain _____

SCHOOL HISTORY

Rate and comment upon child's school experiences related to learning and behavior:

	Good	Average	Poor
Early Intervention Program			
Comments:			
Nursery School/Preschool			
Comments:			
Kindergarten			
Comments:			
Elementary School			
Comments:			
Middle School			
Comments:			
High School			
Comments:			
Current Grade			
Comments:			

Does your child's teacher describe any of the following as significant classroom problems for your child? Please check and comment briefly (teacher may complete this section):

CHILD'S NAME _____

Often fidgets with hands or feet or squirms in seat

Comments: _____

Often leaves seat

Comments: _____

Often runs about or climbs excessively in situations in which it is inappropriate

Comments: _____

Difficulty playing quietly

Comments: _____

Often in "on the go" or often acts as if "driven by a motor"

Comments: _____

Often talks excessively

Comments: _____

Often blurts out answers before questions have been completed

Comments: _____

Often had difficulty awaiting turn

Comments: _____

Often interrupts or intrudes on others

Comments: _____

Does not cooperate well in group activities

Comments: _____

Often fails to give close attention to details or makes careless mistakes

Comments: _____

Often has difficulty sustaining attention

Comments: _____

Often does not seem to listen when spoken to directly

Comments: _____

Often does not follow through on instructions and fails to finish

Comments: _____

Often has difficulty organizing

Comments: _____

Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort

Comments: _____

Often loses things necessary for activities

Comments: _____

Often is distracted by extraneous stimuli

Comments: _____

Often is forgetful

Comments: _____

Describe any other classroom behavior problems: _____

Teacher signature: _____ Date: _____

HOME BEHAVIOR

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an EXCESSIVE or EXAGGERATED degree when compared to other children his or her own age:

Excessive or Exaggerated	
<input type="checkbox"/>	Fidgets with hands, feet or squirms in seat
<input type="checkbox"/>	Has difficulty remaining seated when required to do so
<input type="checkbox"/>	Runs about or climbs excessively in situations in which it is inappropriate
<input type="checkbox"/>	Has difficulty playing quietly
<input type="checkbox"/>	“On the go” or acts as if “driven by a motor”
<input type="checkbox"/>	Often talks excessively
<input type="checkbox"/>	Blurts out answers before questions have been completed
<input type="checkbox"/>	Has difficulty awaiting his/her turn
<input type="checkbox"/>	Interrupts or intrudes on others (often no purposeful or planned, but impulsive)
<input type="checkbox"/>	Easily distracted by extraneous stimulation
<input type="checkbox"/>	Fails to give close attention to details or makes careless mistakes
<input type="checkbox"/>	Has difficulty sustaining attention during tasks or play activities
<input type="checkbox"/>	Does not listen when spoken to directly
<input type="checkbox"/>	Has problems following through with instructions and fails to finish chores or duties
<input type="checkbox"/>	Has difficulty organizing tasks and activities
<input type="checkbox"/>	Avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort
<input type="checkbox"/>	Loses things necessary for tasks or activities at home
<input type="checkbox"/>	Is forgetful in daily activities
<input type="checkbox"/>	Temper tantrums/outbursts
<input type="checkbox"/>	Aggression towards others
<input type="checkbox"/>	Does not seem to learn from experience
<input type="checkbox"/>	Poor memory
<input type="checkbox"/>	A “different” child

Does your child create more problems, either purposeful or non-purposeful, within the home setting than his or her siblings?

Types of discipline you use with your child

Is there a particular form of discipline that has proven most effective?

Have you participated in a parenting class or obtained other help concerning discipline and behavior management? _____

PEER RELATIONSHIPS

Does your child seek friendships with peers? _____

Is your child sought out by peers for friendship? _____

Does your child play with children primarily his or her own age? _____

Younger? _____ Older? _____

Describe briefly any problems your child may have with peers _____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests?

What are your child's areas of greatest accomplishment?

What does your child dislike doing most?

What do you like most about your child?

FAMILY HISTORY/ (IF CHILD IS ADOPTED THEN FILL OUT ALL KNOWN INFORMATION)

Mother _____ Age _____

Currently: Married ___ Single ___ Divorced ___ Widowed ___ Separated _____

Years married to current spouse: _____

School: Highest grade completed _____

Learning problems _____

Attention problems _____

Behavior problems _____

Medical problems _____

Have any of your blood relatives experienced medical (especially ventricular arrhythmias), developmental, neurological, psychiatric or emotional difficulties? If so, briefly describe:

Father _____ Age: _____

Currently: Married ___ Single ___ Divorced ___ Widowed ___ Separated ___

School: Highest grade completed _____

Learning problems _____

Attention problems _____

Behavior problems _____

Medical problems _____

Have any of your blood relatives experienced medical (especially ventricular arrhythmias), developmental, neurological, psychiatric or emotional difficulties? If so, briefly describe:

Child's Siblings:

	Name	M/F	Date of Birth	Age	Grade / Occupation
1					
2					
3					
4					
5					
6					

Have any of your child's siblings experienced medical, developmental, neurological or emotional difficulties? If so, briefly describe:

Has this child or any siblings previously been evaluated by The Child Development Center (who and when)? _____

How long has this child lived in current home? _____ List age of child at any previous moves and how the move was tolerated _____

In the case of divorce, please provide custody documents. List visitation schedule _____

CHECKLIST FOR CHILD DEVELOPMENT CENTER EVALUATION

Your child is being seen by developmental specialists at the Child Development Center. We want to know everything about your child to assure that your child will receive a thorough evaluation. Please provide copies for any of the following items that apply. Please return these records as soon as possible at the Intake appointment or, if you do not have an Intake appointment, at least 48 hours before your first scheduled appointment. You can request information to be sent to us: Child Development Center, ATTN: Intake worker, Morristown Memorial Hospital #100, 100 Madison Avenue, Morristown, NJ 07962. Our fax is (973)290-7164. You may complete a RELEASE OF INFORMATION form so that we can obtain records for you. (Attached)

- _____ Copy of immunization record (MANDATORY)
- _____ Behavior questionnaires (sent separately) for Parent and Teacher
- _____ Birth records, if other than normal, uncomplicated delivery (i.e., prematurity, birth complications, NICU admission, any concerns you have regarding the pregnancy or delivery)
- _____ Early Intervention Program evaluations and progress notes
- _____ Current and previous Child Study Team reports (include social history, educational, psychological, neurodevelopmental, psychiatric, any PT, OT or Speech)
- _____ IEPs (Most recent Individualized Education Program)
- _____ Occupational, Speech/Language and Physical Therapy reports
- _____ Please also include past standardized testing, report cards, and educational evaluations
- _____ 504 Educational Plan
- _____ Pediatric records from primary care doctor

Please indicate if your child has been to see any of the following specialists. List date and evaluator and bring reports/results if available.

- | | |
|--|--|
| _____ Ophthalmology/Optometry | _____ Audiology/Hearing |
| _____ Neurological, Neurodevelopmental | _____ ENT specialist |
| _____ Psychological/Psychiatric | _____ Gastro-enterology |
| _____ Cardiac | _____ Pulmonology |
| _____ Endocrinology | _____ Genetics |
| _____ Other | _____ Any relevant MRI, EEG, CT scans, lab work, chromosomes, thyroid testing, allergy tests |

RELEASE OF INFORMATION

I do hereby consent to and authorize

_____ to disclose my child's records to:

Intake worker

Child Development Center #100

Morristown Memorial Hospital

100 Madison Avenue

Morristown, N.J. 07962

FAX: (973) 290-7164 PHONE: (973) 971-5227

Unless otherwise revoked by me, this authorization is valid for one (1) year from the date above. Revocations **MUST** be made in writing. Revocation may not be made if action has already been taken in reliance on this authorization. I understand that once the requested records are released to the Recipient in accordance with the terms and conditions of this authorization, there is no guarantee by the entity and/or person releasing the information that Recipient will not re-disclose this information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of the requested information. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of the requested information. I hereby, knowingly and voluntarily, authorize AHS to use or disclose the requested information in the manner described above.

Signature of authorized Legal Guardian, Health Care

Relationship

Date

Signature of Witness

Agent or other authorized Personal Representative

NOTICE TO RECIPIENT OF INFORMATION

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules 42C.; F. R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 4.2C.F.R. Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.