Magnolia Regional Health Center Pediatric Evaluation Form

Personal/Identifying Information

Child's name: _____ Date of Birth: _____

Address: _____ City, State, Zip:_____

Phone: _____

Mother's name: _____ Occupation: _____

Personal Phone: _____ Work Phone: _____

Primary caregiver: Yes No Consent to share health information: Yes No

Father's name: _____ Occupation: _____

Personal Phone: _____ Work Phone: _____

Primary Caregiver: Yes No Consent to share health information: Yes No

- If not mother or father, please fill out following:

Primary Caregiver Name: _____ Relationship: _____

Occupation: _____ Personal Phone: _____

Work Phone: _____ Consent to share health information: Yes No

Does the child have any brothers and sisters? If yes, list below:

Name: _____ Relationship: _____ Age:_____

Name: _____ Relationship: _____ Age:_____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Who lives in the home with the child on a daily basis? Please list names and relationship to child below:

_____

_____

_____

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):

_____
_____
_____
_____

Name of hospital where child was born:_____

City, State:_____

Length of Pregnancy:_____ Birth Weight:_____

Was child hospitalized after birth: Yes No If so, how long was child in NICU (in weeks):_____

Was prenatal care received: Yes No Type of Delivery: C Section Vaginal

Did the mother require medical intervention to achieve pregnancy? Yes No

Were there any unusual conditions at or immediately following birth?

_____

Describe any medical attention mother or child required.

_____
_____

Medical History

Does your child have a medical diagnosis (i.e. Autism, Intellectually disabled, ADHD, etc.)? If so, please list diagnosis and age diagnosed

_____
_____

Check any illnesses that child has had and approximate ages:

Allergies	Asthma
Chicken Pox	Convulsions
Ear Infections	Encephalitis
Headaches	High Fever
Influenza	Measles
Meningitis	Mumps
Pneumonia	Seizures
Sinusitis	Tonsilitis

Other: _____

Has your child ever been examined by any of the following providers:

Provider	Dates of Exam/Eval	Name of provider	Currently Under Providers Care
Neurologist			Yes No
Occupational Therapist			Yes No
Physical Therapist			Yes No
Speech Pathologist			Yes no
Psychologist			Yes No
Orthopedic Physician			Yes No
Cardiologist			Yes No
Developmental Pediatrician			Yes No
Social Worker			Yes No
Behavioral Specialist			Yes No
ENT			Yes No

Has the child has any surgeries? If so, what type and when? (i.e. ear tube placement, tonsillectomy, heart surgeries, etc.):

_____

_____

Is your child currently on any medications? Yes No
Please list names and schedule of medications: _____

_____

Allergy	Yes/No	To What	Reaction	Treatment
Skin				
Food				

Other: _____

Developmental History

In your opinion, how does your child's development compare to that of other children?

_____
_____
_____

How would you describe your child's personality?

_____
_____

What does your child enjoy doing?

_____
_____

Check what your child is able to do with approximate age child performed these activities:

Lift head while on belly	Roll (back to belly, belly to back)
Sat unsupported	Crawled
Stood	Cruised
Walked	Fed self
Dressed/undressed Self	Held objects
Drank from cup	Ate with spoon/fork
Used Toilet	Bathed himself/herself

SPEECH & LANGUAGE HISTORY

During the first year, other than crying, how would you describe your child:
A silent baby _____
A very quiet baby _____
An average noisy baby _____
Very noisy baby _____
Please describe his/her vocalizations/sounds:
_____.
At what age did he/she say her first word?
_____
Did he/she get one or two words and then go a long time before getting any new words? Yes No

At what age did he/she use two-word combinations like "want cookie?" _____

At what age did he/she use complete short sentences like "I go upstairs?" _____

Were these easy to understand? Yes No

What efforts does (or did) your child make to communicate his/her wants when not understood?
_____

Did speech learning ever seem to stop for a period? □ Yes □ No
If so, describe:

_____
_____ _

How easily can your child follow instructions?

_____

Do you have to frequently repeat instructions? □ Yes □ No

Does he/she seem to have any difficulty hearing? □ Yes □ No

Does he/she have any visual problems? □ Yes □ No

What have you done to help your child's speech and language?

_____
_____

Sensory Information

Does your child appear to be bothered by bright lights? If so, list behaviors below:

_____
_____

Does your child have a bad reaction to:

Loud noises	Yes	No
Dirt, paint, etc. on hands	Yes	No
Certain food textures	Yes	No
Having teeth brushed	Yes	No
Having hair brushed	Yes	No
Tags in clothing	Yes	No
Wearing socks or tight clothing	Yes	No
Car sickness	Yes	No
Being touched	Yes	No

Is your child what some might call hyperactive? If so, please describe some of the behaviors that lead people to say this (i.e. can't sit still, fidgets, always on the go, etc.).

Does your child seem overly lazy (never wants to do any activities)?

Does your child have a normal response to pain?

General Developmental/Educational History

Present School: _____

City, State:_____ Grade:_____

Performance in school:

Below Average Average Above Average

List the best/favorite subjects:

_____

_____

List the most difficult/least favorite subjects:

_____

_____

Has your child repeated a grade? □ Yes □ No
If so, which grade(s)? _____
Does your child have an
IFSP □ Yes □ No
IEP □ Yes □ No
504 plan □ Yes □ No

Please list any other services your child receives at school and names of provider (i.e. occupational, speech, and/or physical therapy, etc.)

Service: _____ Provider Name:_____

Service: _____ Provider Name:_____

Service: _____ Provider Name:_____

Service: _____ Provider Name:_____

In your opinion, how does your child's development compare to that of other children?

_____

_____

_____

How would you describe your child's personality?

_____

Why are you bringing your child in for an evaluation? What are the problems you have been noticing?

What are some goals you have for your child while he/she is receiving therapy?

_____
_____
_____