

Pediatric History Form

IDENTIFYING INFORMATION

Child's Name	
Date of Birth and Birth order (e.g. 1 st of three)	
Child's Diagnosis (if known)	
Child's Age upon completion of this form	Years_____ Months_____
Person completing this form	
Parents' / Guardian's names:	
Best Phone number(s) to reach Parents/guardians	
Best time to reach Parents/Guardians	
Date form completed	
Referred by	

What are you hoping to learn from this evaluation?

What questions do you have about autism and/ or the treatment of autism spectrum disorders?

Primary care physician: _____ **Phone number:** _____

Address: _____

HeartLight Healing Arts
9145 Guilford Road, Suite 100
Columbia, MD 21046

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of HeartLight
(Patient Name) Healing Arts' Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Date

Acceptable Methods of Disclosure
of Protected Health Information

How would you like to be contacted re: answers to questions, lab requests, etc.?
(Please check ALL that apply)

_____ Home Phone: _____
_____ Work Phone: _____
_____ Cell Phone: _____
_____ FAX: _____
_____ Other: Please specify _____

If we are unable to reach you, should we leave a message to include protected health information?

_____ Yes _____ No

If so, where should we the leave the information?
(Please check ALL that apply)

_____ Home Phone
_____ Work Phone
_____ Cell Phone
_____ Leave a message with spouse or significant other
_____ Other: Please specify _____

Signature of Patient or Legal Guardian

Date

Part 1: Medical History

a. Review of Pregnancy

Questions	Your responses	Providers Notes (PLEASE LEAVE BLANK)
Maternal age during pregnancy?		
Single or multiple pregnancy?		
Complications during pregnancy? (bleeding, high blood pressure, infections, diabetes, etc.)		
Maternal weight gain during pregnancy?	_____ lbs	
Maternal Medications during pregnancy?		
Maternal exposures during pregnancy? (Circle all that apply)	<ul style="list-style-type: none"> • Tobacco • Alcohol • Tuna/Salmon • Dental Filings with mercury • Rhogam shot (for RH neg blood types) • Influenza vaccine • Other _____ 	
Amniocentesis during pregnancy? If yes, please indicate the concern and the results.		
Ultrasounds during pregnancy? If yes, please indicate the concern and the results.		
During pregnancy, was your child unusually active or under-active?		

b. Review of Birth and Early Infancy

Questions	Your responses	Providers Notes (PLEASE LEAVE BLANK)
Place of Birth?		
Gestational Age of infant? Full-term or Premature? If Premature, how many weeks?		
Type of delivery? Vaginal or C-section. If C-section, Why?		
Apgar scores?		
Birth weight?	_____ lbs _____ oz	
Birth and or post-delivery Complications?	<ul style="list-style-type: none"> • Jaundice • Respiratory • Infection • Low blood sugars • Poor feeding • Cardiac conditions • Brain Hemorrhages • Other <p>_____</p>	
Treatment for birth and or post- delivery complications	<ul style="list-style-type: none"> • Phototherapy • Oxygen therapy, Ventilator • Antibiotics • Emergency surgery • Apnea monitor • Other <p>_____</p>	
Any problems in early infancy?	Unusually quiet Unusually active Unusually stiff Unusually floppy Colic/ Excessive crying Feeding problems	

Did your infant have any abnormal results on State Metabolic screening at 24 hours of life and at 2 weeks of age?		
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c. Review of General Health

Questions	Your responses	Providers Notes (PLEASE LEAVE BLANK)
Are your child's immunizations up-to-date?		
Did your child have any adverse reactions to immunizations?		
Has your child had any problems with his or her overall growth? (Height, weight, head circumference)		
Has your child been diagnosed with any chronic medical conditions? (Asthma, Diabetes, other)		
Is your child currently on any prescribed routine medications? Please list all medications, dosages and frequency given ***PLEASE DO NOT LIST VITAMENS OR NUTRITIONAL SUPPLEMENTS	1. _____ Date Started _____ 2. _____ Date Started _____ 3. _____ Date Started _____	

Does your child have any adverse or allergic reactions to any medications? Please list the medication and describe any reaction that he or she has.		
Does your child have any frequent illnesses? Please describe.		
Is your child prescribed antibiotic frequently? Please describe		
Has your child had any serious illness? Please describe.		
Has your child had any serious injury? Please describe.		
Has your child had any surgeries? Please describe.		
Has your child ever been hospitalized? Please describe.		
When was the last time your child had baseline or routine blood work or urine studies? Please describe any concerns or abnormal results?		
Has your child had blood test for lead? Results?		

Has your child ever resided in a home built prior to 1978, in a home with chipped or peeling paint, or with someone heavily involved in construction or building renovations? Please describe.		
When was your child's last routine physical examination? Please describe any concerns or problems identified.		

Part 2. Body Function and Systems Review

a. Neurological

Please indicate whether your child now has, or has ever had any of the following?	If no, please write "no". If yes, please describe and indicate the age of onset or evaluation. For test/evaluations please indicate the results	Providers Notes (PLEASE LEAVE BLANK)
Headaches		
Seizures		
Tics, Twitching, and /or Involuntary movements.		
MRI		
CT Scan		
EEG		
Neurology Evaluation If yes please indicate name of evaluator		

b. Sensory

<p>Please indicate whether your child now has, or has ever had any of the following?</p>	<p>If no, please write “no”. If yes, please describe and indicate the age of onset or evaluation. For test/evaluations please indicate the results</p>	<p>Providers Notes (PLEASE LEAVE BLANK)</p>
<p>Hypersensitivity or hypo sensitivity to sound? (i.e. motorized, toilets flushing, sirens, loud chaotic environments, ect)</p>		
<p>Formal Hearing Evaluation? If yes please provide the name of the evaluator</p>		
<p>Sensitivity to light or visually overwhelming environment?</p>		
<p>Visual impairment? Simulation from bright or flashing lights?</p>		
<p>Formal Vision Evaluation? If yes please provide the name of the evaluator</p>		
<p>Sensitivities to the following? Circle all that apply and briefly describe</p>	<p>Haircuts-</p> <p>Tooth brushing-</p> <p>Getting hands dirty or wet-</p> <p>Walking on the grass-</p> <p>Deep pressure-</p> <p>Rough play, wrestling-</p> <p>Tags on clothing, fabric textures, and/or fit of clothing (tight or loose)-</p> <p>Pain-</p>	

Sensitivities to the following? Circle all that apply and briefly describe	Food Textures- Temperature- Smells (including smelling objects or people)-	
Excessive need to swing, jump, hang upside down, and or stamp feet?		
Formal Occupational Therapy Evaluation? If yes please provide the name of the evaluator		

c. Metabolic/ Endocrine

Please indicate whether your child now has, or has ever had any of the following?	If no, please write “no”. If yes, please describe and indicate the age of onset or evaluation. For test/evaluations please indicate the results	Providers Notes (PLEASE LEAVE BLANK)
Excessive Fatigue?		
Hyperactivity?		
Extreme variations in activity level?		
Excessive weight gain?		
Excessive weight loss?		
Intolerance to cold or heat?		
Night sweating?		
Sleep disturbances?		
Excessive thirst?		

Excessive urination?		
Unusual body odors?		
Blood or urine test for any of the above ?		
Lab test for thyroid function?		
Genetic Evaluations? If yes please provide the name of the evaluator.		
Endocrinology Evaluations? If yes please provide the name of the evaluator.		

d. Cardiac/ Respiratory

Please indicate whether your child now has, or has ever had any of the following?	If no, please write “no”. If yes, please describe and indicate the age of onset or evaluation. For test/evaluations please indicate the results	Providers Notes (PLEASE LEAVE BLANK)
Congenital heart defect?		
Arrhythmia/ Abnormal heart beat?		
Chest pain or apparent discomfort?		
Echocardiogram?		
Cardiology evaluation? If yes please provide the name of the evaluator.		
Frequent Respiratory and related infections? (colds, ear infections, sinusitis, tonsillitis, bronchitis, pneumonias, ect)		
Asthma and or wheezing?		

Allergic rhinitis” hay fever”?		
Snoring?		
Otolaryngology/ ENT Evaluation? If yes please provide the name of the evaluator.		
Pulmonology and/ or Allergy Evaluations? If yes please provide the name of the evaluator.		
Tonsillectomy?		
Ear Tubes?		
Adenoidectomy?		

e. Dermis/ Integument

Please indicate whether your child now has, or has ever had any of the following?	If no, please write “no”. If yes, please describe and indicate the age of onset or evaluation. For test/evaluations please indicate the results	Providers Notes (PLEASE LEAVE BLANK)
Eczema/ Dry skin?		
Chronic rash or skin condition?		
Unusual Birthmarks?		
Unusual coloration of the skin? (dark or light)		
Red cheeks or ears without obvious reason?		

Cracking or peeling nails?		
White spots/ pits on nails?		
Unusual coloration of the nail?		
Hair loss or thinning?		
Dermatology Evaluation? If yes, please provide the name of the evaluator.		

f. Musculoskeletal

Please indicate whether your child now has, or has ever had any of the following?	If no, please write “no”. If yes, please describe and indicate the age of onset or evaluation. For test/evaluations please indicate the results	Providers Notes (PLEASE LEAVE BLANK)
Congenital or acquired conditions of the muscles, joints or extremities? (cerebral palsy, missing limbs, fused/ joined digits, arthritis, ect)		
Frequent joint pain or swelling?		
Fractured/ Broken bones?		
Lack of coordination/ clumsiness		
Orthopedic and/ or Rheumatology Evaluation? If yes, please provide the name of the evaluator.		

g. Gastrointestinal/ Genitourinary

Please indicate whether your child now has, or has ever had any of the following?	If no, please write "no". If yes, please describe and indicate the age of onset or evaluation. For test/evaluations please indicate the results	Providers Notes (PLEASE LEAVE BLANK)
Excessive gas, belching, bloating?		
Stomachaches and or abdominal cramps?		
Reflux?		
Constipation?		
Diarrhea?		
Frequent variations in stool consistency?		
Frequent nausea?		
Frequent vomiting?		
Allergies to specific foods?		
Intolerances to specific foods?		
Gastroenterology Evaluations? If yes, please provide the name of the evaluator.		

Frequent urinary infections?		
Kidney or urinary tract structural abnormalities?		
Abnormalities of reproductive organs?		
Evaluations for conditions of the urinary or reproductive system? (Nephrology, Urology, Gynecology)		

Part 3: Diet/Nutritional History and Review

Questions	Your responses	Providers Notes (PLEASE LEAVE BLANK)
Was your child breastfed?		
If yes, for how long month?		
Did you notice any change in your child's behavior or general health when you ate certain foods while breast feeding?		
If your child was formula fed, at what age did you introduce formula?		
Which formula did your child take?		
Did your child have any adverse reactions to a particular formula?		
At what age did you introduce solids?		
Did your child have any adverse reactions to any food introduced prior to his/her first birthday?		

Does your child have a good appetite?		
Is he/she a picky eater?		
Does your child have any unusual food preferences or dislikes?		
Any food cravings?		
Do any foods seem to make your child's behavior better or worse?		
Have you tried any specific types of diets to see if they affected your child's behavior or development (e.g., milk-free, gluten-free, etc.)? If so, were they helpful?		
Is your child currently taking any vitamins or other nutritional supplements? Has he/she taken any in the past?		
Please list all vitamins or nutritional supplements that your child is currently taking?	1. _____ Date Started _____ 2. _____ Date Started _____ 3. _____ Date Started _____ 4. _____ Date Started _____	

Does your child eat a lot of dairy products? (Milk, cheese, yogurt, etc.)		
Does your child eat a lot of carbohydrates or wheat-containing products ? (Bread, pasta, cereal, cakes, cookies, etc.)		
What type of protein does your child eat? (meat, eggs, peanut butter)		
What type of fruits does your child eat?		
What types of vegetables does your child? (corn is not a vegetable)		
What is a typical breakfast for your child?		
What is a typical lunch for your child?		
What is a typical dinner for your child?		

Part 4: DEVELOPMENT Concerns and History

a. General Developmental Concerns

- Are you concerned about your child's development? _____
- If yes, at what age did you first become concerned? _____

- What concerned you initially?

- What are your main **current** concerns about your child's development?

- What age do you think your child acts like, in terms of development and learning?

- Has your child lost previously attained skills? _____

- If yes, at what age did the loss begin? _____

- What skills were lost? _____

- Was there any event, illness, etc. that appeared to coincide with the loss of skills?

- What are your child's main developmental strengths?

- Has your child had any previous evaluations of his/her development or learning? _____

- If yes, please indicate the type of evaluation, date, and general results. (Please bring any reports of previous evaluations or testing with you to your first appointment.)

b. Language History

- **Language skills:** Please indicate the age at which your child achieved the following skills: (Do not worry if you cannot remember any or all of these milestones; their importance can be determined during our discussion at the first appointment.)

Skill	Age Achieved	Providers Notes (PLEASE LEAVE BLANK)
Social smile (smiled in response to you)		
Laughed		
Babbled		
Said "mama", "dada"		
Understood "no"		
Pointed to communicate		
Said first word		
Spoke in jargon		
Waved bye-bye		
Played "peek-a-boo" or "pat-a-cake"		
Followed a one-step instruction		
Pointed to pictures		
Identified body parts		
Combined two-words		
Had a 50-word vocabulary		
Spoke in short (at least three-word) sentences		
Used pronouns (e.g., I, me, you) correctly		
Able to state full name		
Able to state age		
Identified basic colors		

- **Receptive Language:**

Does your child have trouble understanding what is asked of him/her? _____

Does he/she seem to have difficulty processing information quickly? _____

Does he/she have difficulty following multi-step directions? _____

- **Expressive Language**

Are any languages other than English spoken in the home? _____

Does your child have difficulty expressing himself/herself? _____

Any problems with articulation (clarity of speech)? _____

Has your child been diagnosed with apraxia or dyspraxia? _____

If under age 3 (or if you have concerns in this area), estimated vocabulary size? _____

Does your child use any augmentative communication (sign language, Picture Symbols, or computer devices)?

- **Atypical language**

Does your child have a delay in or lack the development of spoken language?

Can your child initiate or sustain a conversation with others?

If your child can initiate a conversation with others is it limited to only his/her interest?

Does your child repeat or “echoes” what he hears immediately?

Does your child repeat or memorize words/ phrases from books, conversations, or videos?

Is your child unusually literal? (unable to understand get jokes or idioms)?

Did your child have an early or unusual interest in letters or numbers?

- **Language Evaluations**

- Has your child ever had any evaluations of his/her language? _____

If yes, please indicate type of evaluation, date and general results. (Please bring reports of any previous evaluations to your first appointment.)

- Has your child ever received any formal interventions regarding his/her language

difficulties (such as Speech therapy, PROMPT, etc.)?

c. Gross and Fine Motor History

Please indicate the age at which your child achieved the following skills: (Do not worry if you cannot remember any or all of these milestones; their importance can be determined during our discussion at the first appointment.)

Skill	Age Achieved	Providers Notes (PLEASE LEAVE BLANK)
GROSS MOTOR		
Rolled over		
Sat alone		
Crawled		
Pulled to standing		
Cruised around furniture		
Walked independently		
Walked up steps		
Pedaled tricycle		
Rode bicycle:	With training wheels _____ Without training wheels _____	
Skipped		
FINE MOTOR		
Picked up small objects with a pincer (thumb-forefinger) grasp		
Scribbled with a crayon		
Fed self with fingers		
Used spoon		
Used fork		
Drank from a cup		
Toilet-trained		
Undressed completely		
Dressed self completely		
Unbutton		
Button		
Zippers		
Tied shoes		
Able to put shoes on correct feet		

Gross and Fine Motor History (continued)

- Is your child coordinated?

- Is your child right-handed or left-handed?

- Is your child's handwriting legible?

- Does your child have trouble with spacing and sizing of letters and or trouble with page planning (e.g. runs out of room)?

- **Gross and Fine Motor Evaluations**
 - Has you child ever had any evaluations of his/her gross or fine motor development? _____

If yes, please indicate type of evaluation, date and general results. (Please bring reports of any previous evaluations to your first appointment.)

- Has your child ever received any formal interventions regarding his/her motor difficulties such as Physical or Occupational therapy?
-

Part 5: BEHAVIOR Concerns and History

a. General Behavioral Concerns

- Are you concerned about your child's behavior? _____
- .
- If yes, at what age did you first become concerned? _____

What concerned you initially?

- What are your main **current** concerns about your child's behavior?

- What are your child's behavioral strengths?

b. Behavioral History

- Please indicate whether your child has difficulties in any of the following. **Circle all that apply**
 - Hyperactivity
 - Inattention
 - Impulsivity
 - Distractibility
 - Significant variability in behavior from day to day
 - Temper tantrums
 - Oppositional behavior
 - Difficulty getting along with siblings or peers
 - Trouble making friends
 - Aggressiveness
 - Destructiveness
 - Lying
 - Stealing
 - Self-injurious behaviors
 - Bed wetting
 - Depressed mood
 - Mood swings
 - Low self-esteem
 - Sleep problems
 - Withdrawn behavior
 - Anxiety/Nervousness
 - Nail biting
 - Thumb sucking
 - Obsessions
 - Compulsions

- **Social interactions:** Please indicate whether your child displays any of the following. **Circle all that apply.**

- Poor eye contact
- Inability to read facial expressions
- Inability to read body language
- Impaired gesturing (e.g. pointing, waving)
- Lack of interaction with peers
- Inability to initiate interactions
- Lack of true friends
- Treats people like objects/ furniture
- Lack of spontaneous sharing of enjoyment, interest or achievements of others
- Prefers to be alone
- Lack of make-believe play
- Restrictive or repetitive behaviors

- **Restricted or repetitive patterns of behavior:** Please indicate whether your child displays any of the following. **Circle all that apply**

- Pre-occupation with unusual interest or specific topic
- Trouble with transitions
- Need for sameness
- Unusual attachments to objects
- Repetitive motor movements such as:
 - hand or finger flapping, flicking, or twisting
 - jumping or flapping
 - body rocking
 - toe-walking
 - holding objects close to eyes and moving them

- Pre-occupation with parts of objects (e.g.spinning wheels or ceiling fans)

c. Behavioral Evaluations

- Has your child ever had any evaluations of his/her behavior? _____

If yes, please indicate type of evaluation, date and general results. (Please bring reports of any previous evaluations to your first appointment.)

- Has your child ever received any formal interventions regarding his/her behavioral difficulties (such as counseling/therapy, medication, etc.)?
-

Part 6: EDUCATION: Setting and Concerns

a. Setting

- Current school:

- Grade: _____ Estimated number of children in classroom _____
- Type of classroom (Regular education, special education)

- Does your child have an IEP:

If yes, please bring a copy of the most recent one.
- Has your child ever repeated a grade?

b. Concerns

- Do you have any concerns about your child's learning or school placement?
-
-

- What are your child most difficult subjects in school?
-

- What are your child's best subjects in school?
-

- How do you think your child learns best?
Visual learner _____
Auditory learner _____
"Hands on" learner _____

c. Educational Evaluations

- Has your child had any formal testing regarding his/her learning (such as psychological testing, educational testing)?
-

- Is your child receiving any special services at school or outside of school (such as speech-language therapy, occupational therapy, tutoring, etc.)? If yes, please list type of therapy, where received, and the frequency of therapy.
-

Part 6: FAMILY/SOCIAL History and Concerns:

a. Family Medical and Mental Health History

- Please indicate whether the following illnesses/disorders are present in your family's history and who has/had them:

Attention Deficit Hyperactivity Disorder

Learning Disability

Mental Retardation

Autism/Pervasive Developmental Disorder

Language Delay

Articulation Problems

Fragile X Syndrome

Hearing Impairment

Vision Impairment

Seizures

High Blood Pressure

Heart Disease

High Cholesterol

Allergies

Eczema

Asthma

Food Intolerances

Liver Disease

Gastrointestinal Problems (Inflammatory bowel disease, celiac disease, irritable bowel syndrome, etc.):

Night blindness/Trouble seeing at night

Diabetes

Arthritis Autoimmune disorders

Tics/Tourette's Syndrome
 Depression
 Anxiety
 Obsessive-Compulsive Disorder
 Bipolar Disorder (Manic-Depressive Illness)
 Schizophrenia
 Other

b. Social History and Concerns

- How many people currently live in your household? _____
- Are parents: Married? _____ Separated? _____ Divorced? _____
- Father's Age and Occupation: _____
- Mother's Age and Occupation: _____
- Names and ages of siblings, and any behavioral or developmental concerns that they may have:

Names	Ages	Developmental or Behavioral Concerns
1.		
2.		
3.		
4.		
5.		

- Is your child receiving any home-based therapies or special services? (e.g., ABA, Floor-time, RDI, other) If yes, please indicate when therapy or services started.

- Are there any recent social stressors (e.g., deaths/losses, moves, loss of employment, change in family situation, marital discord)?

- Are there any other concerns in regards to your family's emotional and physical health that you have?

Thank you for taking the time to complete this form!