BlueSky NEUROLOGY

CHILD HEALTH AND DEVELOPMENTAL HISTORY FORM

Please complete this form and fax it to Dr. Castelo prior to your appointment (303-697-4086). In addition, please bring along copies of your child's educational plan (IEP or 504 Plan) and any recent testing (CORE evals, neuropsych evals). Thank you.

Today's Date _____

Child's Full Name _____ Date of Birth _____

Your Full Name _____ Telephone (Home) _____

Relationship to Child _____ Telephone (Work) _____

Email: _____

Home Address _____

_____

Name of School _____ Grade _____

School Address _____

Teacher(s) _____

What are you hoping to gain from this evaluation?

_____

_____

_____

_____

_____

_____

_____

What specific questions do you have?

_____

_____

_____

_____

_____

_____

_____

A. BIRTH HISTORY

❑ Unknown (skip to page 3)

Is your child adopted? Y / N If yes, age at adoption _____

Which of the mother's pregnancies was this (1st, 2nd, 3rd, etc.)? _____

Were there miscarriages prior to this pregnancy? NO_____ YES_____ How many? _____

Were there therapeutic abortions prior to this pregnancy? NO_____ YES_____ How many? _____

Age of mother at delivery: _____

Age of father at delivery (if known): _____

During Pregnancy:

❑ Unknown (skip to page 3)

Circle Y (yes) or N (no) if the following occurred. If Y (yes), please list or describe.

Illness.....Y / N Describe _____

Medication taken .....Y / N Describe _____

Bleeding.....Y / N Describe _____

Smoking .....Y / N If YES, how much? _____

Alcohol intake .....Y / N If YES, how much? _____

Weight Gain in Pounds: _____

Length of Pregnancy in Months: _____

Labor:

Induced .....Y / N If YES, give reason _____

Lasted over 12 Hours .....Y / N

Delivery:

Cesarean Section.....Y / N If YES, give reason _____

Anesthesia .....Y / N If YES, what type: Spinal___ Epidural___ General (asleep)____

Newborn:

Birth Weight: _____

Cried right away .....Y / N

Complications .....Y / N If YES, please describe _____

Went home after _____ days in the hospital

Apgar score, if known _____

Infancy:

Enjoyed cuddling.....Y / N Fussy, Irritable Y / N

More active than other babies. Y / N Other:

B. DEVELOPMENTAL HISTORY

If you can recall it, record the age at which your child reached the following developmental milestones. If you cannot recall the age, check an item at right.

		I cannot recall exactly, but to the best of my recollection it occurred:			
	Estimation	Early	At normal time	Late	Not known
Sat without support					
Crawled					
Stood without support					
Walked without assistance					
Spoke first words besides "mama" and "dada"					
Said phrases					
Said sentences					
Spoke clearly					
Showed clear hand preference					
Bowel trained					
Bladder trained, day					
Bladder trained, night					
Rode tricycle					
Rode bicycle (without training wheels)					
Buttoned clothing					
Tied shoelaces					
Named colors					
Named coins					

Current Performance:

How well does your child function in the following areas compared with age peers?

	About like peers	Better than peers	Worse than peers
Walking			
Running			
Throwing			
Catching			
Athletic Abilities			
Understanding Directions			

C. ACADEMIC HISTORY

Please fill in the following table. Grades can be combined if your child received similar supports within the same school.

Does your child currently have an Individualized Education Plan (IEP)? Y / N If yes, for what subjects? _____

Does your child currently have a 504 Plan? Y / N If yes, for what accommodations?

Do you think their educational plan is meeting their needs? Y / N

If not, what additional supports would you like to see in place?

_____

Grade(s)	**School Attended**	**Classroom Type** (for example regular education, inclusion class, special education class)	**Supports provided** (such as aides, speech therapy, occupational therapy, academic & class supports)

D. SOCIAL FUNCTIONING

What are some of your child's favorite activities?

1. _____
2. _____
3. _____
4. _____
5. _____

Does s/he belong to any teams, clubs or participate in group activities? Yes No

If yes, which? _____

_____

How many friends does your child have? _____

Approximately how often does your child get together with friends? _____

How does your child get along with

Siblings (if applicable)? _____

_____

_____

Peers? _____

_____

_____

Parents? _____

_____

_____

Other adults? _____

_____

_____

C. MEDICAL HISTORY

Indicate if your child has had the following by circling Y(es) or N(o).

For adopted children: age at which known medical history begins: _____

Ear infections	Y / N / Unknown	If yes, starting at what age? _____
Were tubes ever put in place?	Y / N / Unknown	
Were antibiotics ever given to prevent ear infections?	Y / N / Unknown	
Hearing problems	Y / N / Unknown	
Vision Problems	Y / N / Unknown	
Allergies	Y / N / Unknown	If yes, to what? _____
Headaches	Y / N / Unknown	
Stomach Aches	Y / N / Unknown	
Heart, lung or kidney problems	Y / N / Unknown	
Seizure	Y / N / Unknown	If yes, at what age? _____
Serious Head Injury	Y / N / Unknown	If yes, at what age? _____
Did child lose consciousness?	Y / N / Unknown	
Surgery	Y / N / Unknown	If yes, for what? _____
Hospitalization	Y / N / Unknown	If yes, at what age? _____

Reason: _____

Lead level in blood testing Y / N / Unknown

Date(s) _____ Numerical value: _____

_____ _____

_____ _____

_____ _____

_____ _____

(This information may be obtained from your pediatrician if you do not have it)

List any other health problems:

1. _____
2. _____
3. _____
4. _____
5. _____

List any medications, and doses, child takes at present:

_____

_____

_____

List dates of any counseling or therapy child or family have received related to child's difficulties:

_____

_____

_____

_____

Describe your child's personality:

_____

_____

_____

_____

_____

What are your greatest concerns about your child's social, emotional or behavioral development?

_____

_____

_____

_____

What are your child's most notable strengths?

_____

_____

_____

_____

_____

D. FAMILY HISTORY

Child lives with (circle all that apply):

Birth Mother	Birth Father
Stepmother	Stepfather
Adopted Mother	Adopted Father
Foster Mother	Foster Father
Another relative _____	Other _____

If child is adopted, please indicate age at adoption: _____

Current Living Situation:

Language spoken at home:_____

Parent 1

Name: _____

Age:_____

Occupation:_____

Relationship to child: _____

Highest school grade completed:_____

Learning problems:_____

Behavior problems:_____

Medical problems (specify):_____

Emotional problems:_____

Drug or alcohol abuse:_____

Parent 2 (if applicable)

Name: _____

Age:_____

Occupation:_____

Relationship to child:_____

Highest school grade completed:_____

Learning problems:_____

Behavior problems:_____

Medical problems (specify):_____

Emotional problems:_____

Drug or alcohol abuse:_____

Parents are (circle all that apply):

Married | Domestic Partners | Living Together

Separated | Divorced

Mother deceased | Father deceased

Other members of the Household (beyond those mentioned above)**:**
☐ **NONE**

Name	Age	Relation to child (ex. Sibling)	Medical, social, academic problems

Birth Family (or parents not living with child):

☐ **Same as above**

☐ **Unknown.**

Parent 1

Name: _____

Age:_____

Relationship to child: _____

Occupation:_____

Highest school grade completed:_____

Learning problems:_____

Behavior problems:_____

Medical problems (specify):_____

Emotional problems:_____

Drug or alcohol abuse:_____

Parent 2 (if known)

Name: _____

Age:_____

Relationship to child: _____

Occupation:_____

Highest school grade completed:_____

Learning problems:_____

Behavior problems:_____

Medical problems (specify):_____

Emotional problems:_____

Drug or alcohol abuse:_____

Siblings living outside the household (if applicable)**:**

☐ **NONE**

Name	Age	Relationship to child (ex: half-brother, step-sister)	Place of residence (ex. Away at college)	Medical, social, academic problems

Please list any relatives on either side of the family who have had the following:

	Relationship to child	Mother's side	Father's side
Behavior problems, including hyperactivity			
Emotional Problems			
Drug or alcohol abuse			
Learning problems			
Ambidexterity or left-hand preference			
Migraine headaches			
Mental retardation			
Childhood diabetes			
Colitis			
Lupus erythematosus			
Rheumatoid arthritis			
Thyroid disease			
Other "immune" disease			
Seizures or epilepsy			
Lead poisoning			
Other neurological problems			

E. Please add any other information you feel would be helpful.