

DEVELOPMENTAL PEDIATRICS – DR CHARLES MIKE RIOS

PATIENT INTRODUCTION FORM

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	MALE FEMALE (circle one)
STREET ADDRESS	CITY	STATE/ZIP
HOME TELEPHONE	SCHOOL (if applicable)	DOCTOR

PARENTS OR GUARDIANS

MOTHER'S NAME	MOTHER'S AGE	LIVES WITH PATIENT	YES	NO
STREET ADDRESS (if not same)	CITY		STATE/ZIP	
HOME TELEPHONE	EMPLOYER	WORK PHONE		
FATHER'S NAME	FATHER'S AGE	LIVES WITH PATIENT	YES	NO
STREET ADDRESS (if not same)	CITY		STATE/ZIP	
HOME TELEPHONE	EMPLOYER	WORK PHONE		

INSURANCE INFORMATION

INSURED (circle one): YES NO SELF-PAY

SUBSCRIBER NAME	SUBSCRIBER SOCIAL SECURITY NUMBER	DATE OF BIRTH
INSURER NAME	GROUP NUMBER	POLICY NUMBER
PHONE NUMBER	RELATION TO PATIENT	EFFECTIVE DATE

REGULAR PEDIATRICIAN/REFERRER

PEDIATRICIAN NAME	ADDRESS	PHONE NUMBER
WHO YOU WERE REFERRED BY: PEDIATRICIAN SCHOOL ECI OTHER (circle one)		

RESPONSIBILITY AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Developmental Pediatrics or my insurance company to release any information required to process my claims.

Parent/Guardian signature

Date

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A. BIRTH HISTORY

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A. NEONATAL HISTORY

HT/WT/HEAD CIRC APPROPRIATE FOR GESTATIONAL AGE	YES	NO	DURATION OF HOSPITAL STAY	_____	
RESPIRATORY DISTRESS/OXYGEN	YES	NO	APNEA/SEIZURES/LOW MUSCLE TONE	YES	NO
HYPOGLYCEMIA/COMA	YES	NO	BRAIN IMAGING	YES	NO
FEEDING PROBLEMS	YES	NO	HEARING SCREEN	YES	NO
EYE EXAM	YES	NO	JAUNDICE	YES	NO
PHOTOTHERAPY	YES	NO			

B. DEVELOPMENTAL HISTORY

EXCESSIVE QUIETNESS	YES	NO	HYPERACTIVITY/IRRITABILITY	YES	NO
COLIC AFTER 2 MONTHS	YES	NO	ALTERED SLEEP/WAKE CYCLES	YES	NO
FEEDING PROBLEMS	YES	NO	FLOPPINESS	YES	NO
TYPE _____			STIFFNESS	YES	NO
DID NOT LIKE BEING CUDDLED	YES	NO	LATE SITTING, WALKING, TALKING	YES	NO

C. IMMUNIZATION HISTORY

Please bring or have your child's immunization records faxed to our office.

RECEIVED ALL VACCINATIONS	ON TIME	DELAYED	SELECTIVE	DID NOT VACCINATE AT ALL
(circle relevant choices)				

D. DEVELOPMENTAL CONCERNS

For children ages birth to 4 years (If over 5 years, skip to section F)

Will follow your pointing to an item	YES	NO
Overreacts to noises	YES	NO
Overreacts to food textures	YES	NO
Unusual fears for age	YES	NO
Unusual rituals (lining objects, holding items in hand, licking, sniffing items)	YES	NO
Repetitive behavior (spinning, hand flapping)	YES	NO
Strong interest in letters or numbers	YES	NO
Sleep Issues	YES	NO
Meltdowns that seem to be severe in terms of length >30mins. , destructiveness	YES	NO
Knows Age	YES	NO
Responds to name by looking at you more than 1-2 seconds	YES	NO
Asks for things	YES	NO
Points to things while making good eye contact with you	YES	NO
Early pointing may thrust hand forward without extending index finger and inconsistent at looking at you	YES	NO
Does not ask or point but rather leads you by hand	YES	NO
Responds to general observations like "Look its raining!"	YES	NO

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E. ADAPTIVE HISTORY

For children ages birth to 4 years

Feeds self with fingers	YES	NO
Feeds self with spoon/fork	YES	NO
Uses cup	YES	NO
Spreads with knife	YES	NO
Dressing self completely	YES	NO
Helps with dressing	YES	NO
Undresses partially (shoes, socks)	YES	NO
Undresses completely	YES	NO
Buttons	YES	NO
Ties shoes	YES	NO
Voids or Defecates when placed on toilet	YES	NO
Initiates toileting	YES	NO
Phrase speech (combining words on regular basis to communicate)	YES	NO
Pronouns (I, me, you, them, they, us)	YES	NO
Initiates conversation for things other than needs, wants or to obtain help	YES	NO

F. DEVELOPMENTAL CONCERNS

For children ages 5-18 (If under 5 years skip to next section)

Reading:		
Alphabet mastery	YES	NO
Reading speed an issue	YES	NO
Reading accuracy an issue	YES	NO
Reading comprehension an issue	YES	NO
Spelling:		
Difficulty with isolated spelling (spelling TESTS)	YES	NO
Difficulty with contextual spelling (Within in written narratives)	YES	NO
Mathematics:		
Problems with math fact recall	YES	NO
Difficulty with word problems	YES	NO
Language:		
Problems describing, relating a sequence or story	YES	NO
Frequent trouble finding words	YES	NO
Difficulty holding verbal directions in memory	YES	NO
Behavior:		
Concerns regarding focus, attention, inability to sit still, repeating similar mistakes	YES	NO
Problems hitting others, destroying objects	YES	NO
Loses temper daily or at least 3 times per week	YES	NO
Stays angry 20-30 minutes or longer	YES	NO
Lots of fears, need for routine/sameness	YES	NO

G. FAMILY HISTORY

Recurrent Miscarriages	YES	NO
Infant deaths	YES	NO
Slow learners, Language delays, special education	YES	NO
Seizures	YES	NO
Depression, Anxiety, Bipolar, Suicide	YES	NO
ADHD	YES	NO
Social Oddness (Recluse, Loner)	YES	NO

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H. CHIEF COMPLAINT

What are the reasons you are inquiring today?

I. PRESENT ILLNESS

What are the main current issues?

J. REVIEW OF SYMPTOMS

Please describe any current problems including disorders, surgery, injuries, and medications to:

HEAD	LUNGS
NOSE	GENITALIA
CHEST	NEURO/BEHAVIOR
ABDOMEN	EYES
MUSCLESKELETAL	NECK
EARS	HEART
MOUTH	SKIN

ANY OTHER CONCERNS or STRESSORS (Separations, divorce, loss of close loved one, posttraumatic event suspected):

K. CURRENT MEDICATIONS AND/OR SUPPLEMENTS

NAME	TYPE	DOSAGE

L. HISTORY OF SURGERIES/HOSPITALIZATIONS/TRAUMA

Please describe and date any trauma, surgeries, or other medical conditions regarding the following parts of the body:

HEAD	EARS
NOSE	MOUTH
CHEST	LUNGS
ABDOMEN	GENITALIA
MUSCLESKELETAL	NEURO/BEHAVIOR
EYES	HEART
NECK	SKIN

M. ALLERGIES AND INTOLERANCES

Please describe any allergies or intolerances experienced by your child.

I certify that the above questions have been accurately answered to the best of my knowledge.

Parent/Guardian signature

Date