The McCarton Center
FOR DEVELOPMENTAL PEDIATRICS

Today's Date:

Child's name:

Child's date of birth:

Home address:

Dear Parent/Guardian,

Please answer the following questions as best as you can. If you have any questions about a specific piece of information, do not be concerned, as there will be an opportunity to discuss the information during the appointment(s).

This form should be completed and returned to The McCarton Center as quickly as possible so that the information can be reviewed before the scheduled appointment date(s).

Thank you.

The McCarton Center for Developmental Pediatrics
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FAMILY COMPOSITION

Name Age Occupation

Cell Phone Email

Name Age Occupation

Cell Phone Email

Please list the child's sibling(s): ☐ N/A

Name Age Gender

Do any family members have developmental delays, learning problems or psychiatric difficulties?

☐ Yes (please explain below) ☐ No

MEDICAL HISTORY

Child's weight at birth? lbs. oz.

Was your child born full term? ☐ Yes ☐ No

If not, at what week of gestation?

How many weeks or months early?

What type of delivery?

☐ vaginal delivery ☐ normal/spontaneous ☐ Pitocin induced

☐ Cesarean section - if so, due to:

How old was the mother at the time of delivery?

What number pregnancy was this (e.g. 1st, 2nd, etc.)?

If any prior pregnancies, how many resulted in a delivery?

Hospital where child was born?

Was your child adopted? ☐ Yes ☐ No

If yes, where was your child born?

How old was your child when he/she was placed in your care?

Was your child conceived through in vitro fertilization? ☐ Yes ☐ No

Did the mother receive fertility therapy? ☐ Yes ☐ No

Was your child a singleton or a multiple birth? ☐ Singleton ☐ Multiple

If a multiple birth, how many children were delivered?

What were their birth weights?

Were there any maternal medical problems during the pregnancy? ☐ Yes ☐ No

If yes, what was/were the problem(s)?

☐ Bleeding ☐ Diabetes ☐ Infection ☐ Hypertension

Were any medications taken during the pregnancy? ☐ Yes ☐ No

If yes, please list medication(s) and reasons taken:

Did you have a fetal sonogram? ☐ Yes ☐ No

If yes, how many?

Result(s) of sonogram(s)? ☐ Normal ☐ Abnormal

If abnormal, please explain:

Was the infant's stay in the nursery:

☐ uneventful ☐ complicated

If complicated, please describe:

Did the infant leave the hospital with mother after usual post-partum stay? ☐ Yes ☐ No

Please list any/all operations, hospitalizations (including emergency room visits) and procedures your child has had:

Procedure	When	Why

Has your child had any severe illnesses? ☐ Yes ☐ No

Illness	When

Has your child had any chronic illnesses, such as ear infections? ☐ Yes ☐ No

Illness	Frequency	Duration

Is your child currently taking medications? ☐ Yes ☐ No

If so, please list medications and reason for taking them:

Does you child have known allergies to food or medications? ☐ Yes ☐ No

If yes, please list:

Pediatric care is provided by:

Name:

Address:

Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any other health care problems:

DEVELOPMENTAL HISTORY

Please list the ages at which your child:

Rolled over

Sat up

Crawled

Stood up

Cruised

Walked alone

Said mama/dada

Single words

2 - word phrases

Toilet trained: ☐ during the day ☐ at night

Please note where your child attended/attends school:

3-year nursery:

4-year nursery:

Kindergarten:

1st grade:

2nd grade:

3rd grade:

4th grade:

5th grade:

6th grade:

7th grade:

8th grade:

High School:

Other:

In the current school placement, please indicate the number of:

students: teachers: aides:

Has your child ever had any of the following evaluations?

	Evaluator	Date

General Findings:

General Findings:

General Findings:

General Findings:

General Findings:

General Findings:

Does/has your child received any therapies?

Therapy	Frequency	Start Date	End Date

Child usually goes to sleep at PM

Child ☐ does / ☐ does not sleep through the night

Child gets up / is wakened at AM

Is your child on a special diet? ☐ Yes ☐ No

If yes, please describe the diet:

Please describe your child and any concerns you have regarding his/her development and/or behavior:

Speech and Language History

What language(s) does your child speak? What is your child's primary language?

What languages are spoken in the home? What is the primary language spoken?

Does your child have a speech or language problem? ☐ Yes ☐ No

If yes, describe it.

When was the problem first noticed?

By whom?

How does your child communicate (gestures, single words, short phrases, sentences)?

Have any other speech & language specialists seen your child? ☐ Yes ☐ No

Who and When?

What were their conclusions or suggestions?

Has your child had an Audiological Exam? ☐ Yes ☐ No

If yes, please provide date(s) and results

Are there or has there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, different textures, etc.)? ☐ Yes ☐ No

If yes, please describe

What Your Child Understands

Describe your child's response to sound:

Does your child react to sounds other than voices?

Does your child turn his/her head toward a sound? (e.g., your child may turn his/her head when the telephone rings.)

If the object that is making the sound is out of sight, will your child look for the object or towards the directions it is coming from?

When someone calls your child's name, does he/she stop what he/she is doing?

Does your child look around to find a person who is talking?

Does your child put toys in his/her mouth?

When you point to a person/object, does your child look at that person/object?

When family members extend their hands and say "Come with me," does your child lean forward to go with them?

Does your child stop what he or she is doing when someone says "no?"

Does your child understand certain words (other than "no") for family members, pets, objects or greetings (for example, your child may raise his or her arms to be lifted when you say "You want up?" or when you say "bye-bye").

If yes, what words does your child understand?

Does your child play with more than one toy at a time? (e.g., he or she may play with two toys, such as banging a truck and a cup on the table or pretend to give a drink to a bear with a cup.)

Does your child follow simple directions, like “go get your shoe?”

Does your child follow directions that have several steps, like “pick up our toys and put them away?”

Does your child know what objects are used for (e.g., you drink from a cup and you bounce a ball)?

Does your child respond to words like “stop” or “wait?”

Does your child understand words for parts of the body? Please indicate:

☐ Nose ☐ Mouth ☐ Eyes ☐ Tummy ☐ Feet ☐ Ears

☐ Hands ☐ Feet Other

Does your child understand the words for clothing? (e.g., does your child raise his or her arms when you say, “Let’s put on your coat on?”

What words for clothes does our child know? Please indicate:

☐ Shoes ☐ Socks ☐ Pants ☐ Shirt ☐ Shorts ☐ Skirt

Other

What Your Child Communicates With You

Does your child make two different vowel sounds, like “a” and “u”?
If yes, please list

Does your child make different constant sounds, like “b” and “m”?
Indicate the sounds your child can make.

☐ P ☐ B ☐ M ☐ N ☐ T ☐ D ☐ K ☐ G

Does your child say two sounds together, like “ba” or “bu?”
If yes, please list

Does your child wave to greet or say goodbye?

Does your child prefer to use words or gestures to let you know what he/she wants?

Does your child use words to:

- Ask for something he/she wants to do or request an object
- Tell you what he/she is doing
- Let you know he/she wants something to happen again
- Ask for help
- Answer yes/no questions

Does your child use question words like “what” or “why?” If yes, please indicate:

☐ Who ☐ What ☐ When ☐ Where ☐ Why ☐ How

How does your child interact with his/her peers (shy, aggressive, uncooperative, etc.)?