Boston Children's Hospital | Neurology

LABEL OR PRINT

NAME

BCH MRN

DOB **GENDER M F**

HEALTH AND DEVELOPMENT HISTORY CHECKLIST OF PARENT OBSERVATIONS

Date _____

Child's full name _____ Date of birth _____

Your full name _____ Telephone (home) _____

Relationship to child _____ Telephone (work) _____

Home address _____

_____

Name of school _____ Grade_____

School address _____

Teacher(s)_____

List the problems with which you want help for this child:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Whose idea was is that this child have an evaluation?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Birth history

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

Were there any miscarriages prior to this pregnancy? Y / N How many? _____

Were there therapeutic abortions prior to this pregnancy? Y / N How many? _____

Age of mother at delivery: _____

Age of father at delivery: _____

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

DURING PREGNANCY

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 PERIOD

Cried right away ..... Y / N

Complications ..... Y / N If YES, please describe_____

Went home after _____ days in the hospital. Apgar score, if known _____

Weight at birth _____

INFANCY

Enjoyed cuddling ..... Y / N

Fussy, irritable ..... Y / N

More active than other babies ..... Y / N Other, please describe: _____

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Medical history

Indicate if your child has had the following by circling Y (yes) or N (no).

Ear infections ..... Y / N Starting at what age? _____

Were tubes ever placed? Y / N

Were antibiotics ever given to prevent ear infections? Y / N

Hearing problems ..... Y / N

Vision problems ..... Y / N

Allergies ..... Y / N To what? _____

Headaches ..... Y / N

Serious head injury..... Y / N Did child lose consciousness? Y / N

Surgery..... Y / N For what? _____

Hospitalization ..... Y / N At what age? _____

Reason? _____

Was your lead level ever tested?..... Y / N If so was it abnormal? ..... Y / N

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

Date(s): Numerical value:

_____ _____

_____ _____

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:

_____

_____

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Review of systems

Please elaborate at the end of the table if you answer YES to any questions.

	Y	N
Is the patient experiencing any fevers?		
Is the patient experiencing any fatigue?		
Is the patient experiencing any weight loss?		
Is the patient experiencing any weight gain?		
Is the patient experiencing any vision changes?		
Is the patient experiencing any blurry vision?		
Is the patient experiencing any light sensitivity?		
Is the patient experiencing any ringing in the ears?		
Is the patient experiencing a sore throat?		
Is the patient experiencing difficulty swallowing?		
Is the patient experiencing any chest pain?		
Is the patient experiencing any chest palpitations?		
Is the patient experiencing any wheezing?		
Is the patient experiencing any coughing?		
Is the patient experiencing any shortness of breath?		
Is the patient experiencing any constipation?		
Is the patient experiencing any diarrhea?		
Is the patient experiencing any nausea?		
Is the patient experiencing any vomiting?		
Is the patient experiencing any urinary difficulties?		
Is the patient experiencing urinary frequency?		
Is the patient experiencing any urinary incontinence?		
Is the patient experiencing any urinary pain?		
Is the patient experiencing any muscle cramping?		
Is the patient experiencing any muscle twitching?		
Is the patient experiencing any muscle weakness?		
Is the patient experiencing any joint pain?		
Is the patient experiencing any swelling?		
Is the patient experiencing any rashes or itching?		
Is the patient experiencing any seizures?		
Is the patient experiencing any speech difficulty?		
Is the patient experiencing any fainting?		
Is the patient experiencing any anxiety?		
Is the patient experiencing any depression?		
Is the patient experiencing any mood changes?		

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	Y	N
Is the patient experiencing any temper changes?		
Is the patient experiencing any hair changes?		
Is the patient experiencing any increase in thirst?		
Is the patient experiencing any increase in appetite?		
Is the patient experiencing any bleeding?		
Is the patient experiencing any bruising?		
Is the patient experiencing any lymphadenopathy ("swollen glands")?		
Is the patient experiencing any fever?		
Is the patient experiencing any hives?		
Is the patient experiencing any sneezing?		
Does the patient have any addictive behaviors?		
Does the patient smoke? If Yes, how often? _____		
Does the patient drink alcohol? If Yes, how often? _____		
Does the patient use drugs? If Yes, what kind? _____ How often?_____		
Does the patient have any other behavioral problems?		

If "Yes" to any of the above please explain.

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HEALTH AND DEVELOPMENT HISTORY CHECKLIST OF PARENT OBSERVATIONS

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
MOTOR DEVELOPMENT				
Good head control				
Rolled over				
Sat up				
Crawled				
Stood without support				
Walked without assistance				
Walked well				
Run				
Showed hand preference				
Tied shoelaces				
Pedaled tricycle				
Rode bicycle w/o training wheels				
LANGUAGE DEVELOPMENT				
Babbled				
Pointed to request				
Said first words				
What was first word?				
VOCABULARY GROWTH				
# of words at 18 months?				
# of words at 2 years?				
# of words at 3 years?				
Said phrases				
Said sentences				
Named actions (verbs)				
Named colors				
Named coins				
SELF CARE				
Bowel trained				
Bladder trained day				
Bladder trained night				

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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			

Does the child receive any rehabilitation services, such as physical, occupational or speech/language therapies? If so, please list:

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Family History

Language spoken at home: _____

PARENT 1: NAME: _____

Age: _____

Occupation: _____

Highest school grade completed: _____

Learning problems: _____

Behavioral problems: _____

Medical problems (specify): _____

Emotional problems: _____

Drug or alcohol use: _____

PARENT 1: NAME: _____

Age: _____

Occupation: _____

Highest school grade completed: _____

Learning problems: _____

Behavioral problems: _____

Medical problems (specify): _____

Emotional problems: _____

Drug or alcohol use: _____

PARENTS ARE

Married.....Y / N

Living together.....Y / N

Seperated.....Y / N

Divorced.....Y / N

Mother deceased .....Y / N

Father deceased .....Y / N

CHILD LIVES WITH

Both parents.....Y / N

Mother .....Y / N

Father .....Y / N

Other (specify) _____

SIBLINGS

	Name	Age	Medical, social, academic problems
1.			
2.			
3.			
4.			
5.			

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HEALTH AND DEVELOPMENT HISTORY CHECKLIST OF PARENT OBSERVATIONS

Family history, continued

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			
Drug or alcohol abuse			
Emotional problems			
Learning problems			
Ambidexterity or left-hand preference			
Migraine headaches			
Intellectual Disability			
Childhood diabetes			
Colitis			
Lupus erythematosus			
Rheumatoid arthritis			
Thyroid disease			
Other "immune" disease			
Seizures or epilepsy			
Lead poisoning			
Tics or movement disorders			
Muscle disorders			
Genetic disorders			
Other neurological problems			

Please add any other information:

_____

_____

_____

Parent/Guardian signature: _____ Date: _____

_____ _____ _____ _____

MD signature | Print name | Date MD reviewed | Time

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