Developmental Behavioral Pediatrics of Central Florida

New Patient Form

Please fill in the fields on your computer, save this form to your computer, and then e-mail the completed form to:
DrCely2@DevelopmentalPediatricsFlorida.com

Child's Information

Name

(Last) _____ (First) _____ (Middle) _____

Child's nickname: _____

Date of birth: _____ / _____ / _____

Age: _____

Gender: ◉ Boy ○ Girl

Referred by: _____

Pediatrician: _____

Parent/Guardian Information

Person filling this form: _____

Form fill date: _____ / _____ / _____

Primary Parent/Guardian

Relation: _____

Relation type: ◉ Natural ○ Step ○ Adoptive ○ Guardian

Name

(Last) _____ (First) _____ (Middle) _____

Date of birth: _____ / _____ / _____

Address

Street: _____

City: _____ State: _____ ZIP: _____

Phone

(Cell) _____ - _____ - _____ (Home) _____ - _____ - _____ (Work) _____ - _____ - _____

E-mail: _____

Secondary Parent/Guardian

Relation: _____

Relation type: ◉ Natural ○ Step ○ Adoptive ○ Guardian

Name

(Last) _____ (First) _____ (Middle) _____

Date of birth: _____ / _____ / _____

Address (if different from Primary Parent/Guardian)

Street: _____

City: _____ State: _____ ZIP: _____

Phone

(Cell) _____ - _____ - _____ (Home) _____ - _____ - _____ (Work) _____ - _____ - _____

E-mail: _____

Emergency Contact

Relation: _____

Name: _____

Phone: _____ - _____ - _____

Phone Type: ◉ Cell ○ Home

Insurance Information

Primary Insurance

Carrier: _____ Plan: _____

Member ID: _____ Group: _____

Policy Holder

(Name) _____

(Date of birth) _____ / _____ / _____

Secondary Insurance

Carrier: _____ Plan: _____

Member ID: _____ Group: _____

Policy Holder

(Name) _____

(Date of birth) _____ / _____ / _____

Concerns

Describe your concerns about your child:

Age when initially concerned: _____

Evaluations and Services

Previous/Current developmental/psychiatric diagnoses/evaluations:

Previous/Current Services/Therapies (outside of school)

Psychiatric/Developmental Evaluation	○ Yes ◉ No	Agency:
Psychotherapy	○ Yes ◉ No	Agency:
Behavior Therapy	○ Yes ◉ No	Agency:
Counseling	○ Yes ◉ No	Agency:
Occupational Therapy	○ Yes ◉ No	Agency:
Physical Therapy	○ Yes ◉ No	Agency:
Speech/Language Therapy	○ Yes ◉ No	Agency:
Applied Behavior Analysis	○ Yes ◉ No	Agency:
Social Skills Training	○ Yes ◉ No	Agency:
Other:		Agency:

Previous/Current service/therapy comments:

About Your Child

Describe your child:

Sleep habits:

Feeding habits:

Pregnancy/Birth History

Pregnancy term: _____ weeks _____ days (optional)

Complications:

Child's Medical History

Previous/Current Medical Diagnoses

Cardiac problems	○ Yes ◉ No	High cholesterol	○ Yes ◉ No
Arrhythmias	○ Yes ◉ No	Diabetes	○ Yes ◉ No
High blood pressure	○ Yes ◉ No	Liver problems	○ Yes ◉ No
Long QT syndrome (type of arrhythmia)	○ Yes ◉ No	Kidney problems	○ Yes ◉ No

Other medical diagnoses:

Seen by neurologist ○ Yes ◉ No

Brain MRI results ○ Normal ○ Abnormal ◉ N/A

EEG results ○ Normal ○ Abnormal ◉ N/A

Neurology comments:

Vaccines are up to date ○ Yes ◉ No

Vaccination comments:

Surgeries:

Hospitalizations:

Family Structure

Primary Parent/Guardian

Name: _____

Occupation: _____

Secondary Parent/Guardian

Name: _____

Occupation: _____

Child's Siblings

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Parents live together ○ Yes ◉ No

Parents are separated ○ Yes ◉ No

Parents are divorced ○ Yes ◉ No

Custodial issues ○ Yes ◉ No

If there are any custodial issues, please describe them here:

Family Medical History

Previous/Current Medical Diagnoses

Cardiac problems	○ Yes ◉ No	ADHD	○ Yes ◉ No	Autism	○ Yes ◉ No
Arrhythmias	○ Yes ◉ No	Depression	○ Yes ◉ No	Anxiety	○ Yes ◉ No
High cholesterol	○ Yes ◉ No	Bipolar disorder	○ Yes ◉ No	Cognitive disability	○ Yes ◉ No
Long QT syndrome (type of arrhythmia)	○ Yes ◉ No	Seizures	○ Yes ◉ No	Learning disability	○ Yes ◉ No
Thyroid disease	○ Yes ◉ No	Suicide	○ Yes ◉ No	Other:	

Family medical history comments:

Child's Education

Grade: _____ School name: _____

School type: (click arrow to select) v

IEP ○ Yes ◉ No

504 Plan ○ Yes ◉ No

Pulled-out services and/or resource room ○ Yes ◉ No

Accommodations at school:

Area(s) of strength:

Area(s) of weakness:

Any grade(s) repeated? ○ Yes ◉ No

Grade repetition comments:

Problems at school:

Services/Therapies (in school)

Occupational Therapy	○ Yes ◉ No
Speech/Language Therapy	○ Yes ◉ No
Other:	

Service/therapy comments:

Child's Medications

Does your child have any allergies to medications? ○ Yes ◉ No

List allergies to medications:

Current medications:

Previous medications/side effects:

Over-the-counter medications/vitamins/supplements:

Developmental History

Developmental history seems to be: ◉ Normal ○ Abnormal

Current age level of function: _____

Gross motor concerns:

Walked at (age): _____

Fine motor concerns:

Language concerns:

Used 50 words at (age): _____

Combined 2 words at (age): _____

Review of Systems

Physiological

Headaches	○ Yes ◉ No	Palpitations	○ Yes ◉ No	Anemia	○ Yes ◉ No
Low muscle tone	○ Yes ◉ No	Heart murmurs	○ Yes ◉ No	Birth marks	○ Yes ◉ No
Vision deficit	○ Yes ◉ No	Constipation	○ Yes ◉ No	Short stature	○ Yes ◉ No
Hearing deficit	○ Yes ◉ No	Stomach aches	○ Yes ◉ No	Premature puberty	○ Yes ◉ No

Sensory

Unusually sensitive to hearing	○ Yes ◉ No	Easily over-stimulated	○ Yes ◉ No
Unusually sensitive to smell	○ Yes ◉ No	Bothered by how things feel	○ Yes ◉ No
Over-sensitive to pain	○ Yes ◉ No	Sensory seeking	○ Yes ◉ No
Under-sensitive to pain	○ Yes ◉ No	Other:	

Interpersonal/Social

Poor eye contact	○ Yes ◉ No	Hard to get child's attention	○ Yes ◉ No
Unusual play/no pretend play	○ Yes ◉ No	Does not use gesturing	○ Yes ◉ No
Seems preoccupied/ distant/aloof	○ Yes ◉ No	Unusual/limited interests	○ Yes ◉ No
Does not use words to communicate	○ Yes ◉ No	Repetitive behaviors (please specify below)	○ Yes ◉ No
Takes things too literally/ misses the point	○ Yes ◉ No	Echolalia	○ Yes ◉ No
Prefers to be alone/Ignores others	○ Yes ◉ No	Handles change poorly/ Insists on sameness	○ Yes ◉ No
Speaks in unusual tone/manner	○ Yes ◉ No	Difficulty relating to peers and/or making friends	○ Yes ◉ No

Repetitive Behaviors

Thumb sucking	○ Yes ◉ No	Rocking	○ Yes ◉ No	Aligns/sorts objects	○ Yes ◉ No
Head banging	○ Yes ◉ No	Handflaps	○ Yes ◉ No	Slaps/bites self	○ Yes ◉ No
Head nodding/shaking	○ Yes ◉ No	Toe walking	○ Yes ◉ No	Pica	○ Yes ◉ No
Tics	○ Yes ◉ No	Pacing	○ Yes ◉ No	Other:	

Other Behaviors

Runs away	○ Yes ◉ No	Fire setting	○ Yes ◉ No	Bed wetting	○ Yes ◉ No
Lying	○ Yes ◉ No	Hallucinations	○ Yes ◉ No	Soiling underwear	○ Yes ◉ No
Wished to be dead	○ Yes ◉ No	Cruel to animals	○ Yes ◉ No	Screaming/ squealing	○ Yes ◉ No
Suicidal ideation	○ Yes ◉ No	Mood swings	○ Yes ◉ No	Screen time (hrs/day):	
Stealing	○ Yes ◉ No	Aggression	○ Yes ◉ No	Other:	

Additional informaton: