Washington University in St. Louis
SCHOOL OF MEDICINE

**History and Referral Form**
**Developmental Behavioral Pediatrics Clinic**

*Thank you for considering our clinic as a place for your family's care. Please fill out the following as completely as possible. Our intake staff will review your paperwork and determine if our clinic is the best place to help your child before contacting you for scheduling or resources.*

Please fax the completed form to 833-969-0131 or email to DBPediatrics@wustl.edu. If you have any questions, please call 314-454-6300.

## Child/Patient Information:

Last Name: _____ First Name:_____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Best Contact Number: _____ Whose Number is this? _____

Who does this child live with? _____ Relationship to child: _____

Is this the child's legal guardian? _____ If not, who is? _____

Language(s) spoken by the child: _____

Other languages spoken in the home: _____

Will you need a translator? Yes/ No What language should the translator speak? _____

## Parent Guardian Information

**First Parent**/Guardian Full Name: _____

Best Contact Number: _____ Email: _____

**Second Parent**/Guardian Full Name: _____

Best Contact Number: _____ Email:_____

Parents are (please circle):

- Married / Separated/ Divorced/ Widowed/ Unmarried

If parents are divorced, who has legal custody (please circle)? Mother/ Father/ Joint/ Other

- If other, please specify: _____

- If parents are separated or divorced is there any disagreement regarding whether the child should receive clinical services through our department? Yes/No

- If parents are separated or divorced is there a court ordered parenting plan or divorce decree that outlines parental rights related to the child's medical care? Yes/No

- Are you hoping to use this evaluation in any legal proceedings? Yes/No

- ***Please provide documentation regarding custody, we may not be able to evaluate your child unless this has been received.***

- If parents are divorced or separated, how often does the child visit the parent that he or she does not live with?

  _____

- Is this child a foster child? Yes/No

- Is this child adopted? Yes/No
  - If yes, please give as much information regarding biological parent(s) as you can:

    _____

    _____

    _____

    _____
  - If a foster child or adopted child, how long has the child been in your home? _____
  - If a foster child or adopted child, is this child aware that they are a foster child or adopted? Yes/No

## Referral History (Please be as SPECIFIC as possible):

1. Who referred your child to this clinic? _____
2. Why were you referred to this clinic? _____

Please check the following reasons you are interested in an evaluation:

- Evaluate my child's attention and/or hyperactivity problems
- Evaluate my child's learning problems
- Evaluate my child's developmental delays (language skills, motor skills, social skills)

- ☐ Evaluate to determine if my child has an autism spectrum disorder
- ☐ Evaluate for anxiety
- ☐ General behavior concerns
- ☐ Medication consultation
- ☐ For a second opinion of my child's diagnosis, which is:_____

3. In the space below, please list your main concerns that you have for your child and what you hope to gain from this visit:

4. When did these problems begin? _____
5. What helps the problems? _____
6. What makes them worse? _____
7. Has your child received an evaluation or treatment for these problems before? Yes/No
   - If yes, when and with whom? _____

**PLEASE PROVIDE A COPY OF ANY PRIOR EVALUATION INCLUDING SCHOOL EVALUATIONS.**

   - What was your child's diagnosis at that evaluation? _____
   - Does your child's school have any concerns about your child's behavior (even if not evaluated)? Yes/No.

If yes, please explain. (i.e., what are the concerns, when did these concerns begin.)

_____

_____

## Brief Family History:

- Has anyone in the child's family experienced the following:

| | | | Who (relationship to child) |
|---|---|---|---|
| Speech or language problems | ☐ yes | ☐ no | _____ |
| Held back in school | ☐ yes | ☐ no | _____ |
| Intellectual Disability | ☐ yes | ☐ no | _____ |

| | | | | | |
|---|---|---|---|---|---|
| ADHD (Attention Deficit Hyperactivity Disorder) | ☐ | yes | ☐ | no | _____ |
| Autism | ☐ | yes | ☐ | no | _____ |
| Learning Disabilities | ☐ | yes | ☐ | no | _____ |
| Genetic disorder | ☐ | yes | ☐ | no | _____ |
| Suicide or attempted suicide | ☐ | yes | ☐ | no | _____ |
| Depression | ☐ | yes | ☐ | no | _____ |
| Anxiety | ☐ | yes | ☐ | no | _____ |
| Diagnosed with Manic-Depression | ☐ | yes | ☐ | no | _____ |
| Seizures / Epilepsy | ☐ | yes | ☐ | no | _____ |
| Neurological disease/disorder | ☐ | yes | ☐ | no | _____ |

- Please list anyone in the family who is left-handed or ambidextrous (mixed-handed):
  1._____ 3._____
  2._____ 4._____

## Pregnancy and Birth History:

**A. Pregnancy and Delivery – this section is to be completed by the child's mother if possible.**

Length of pregnancy (how many weeks/months?) _____

Did you attend regular prenatal care? Yes/No

Mother's age when child was born _____

Child's birth weight _____

Delivery was by: Vaginal birth/ C-section

Were forceps used? Yes/ No

Was it a breech birth? Yes/ No

Length of labor _____

Problems with delivery Yes/ No

(If yes, please describe; e.g., emergency cesarean section, slow heart rate, fever, cord around neck, etc.)

_____

_____

_____

**B. Biological Mother's Health During Pregnancy**

- Did the child's mother experience any of the following during pregnancy?
- Bleeding Yes/ No
- Gained 30 or more pounds Yes/ No
- Had toxemia or high blood pressure Yes/ No
- Had to take prescription medications Yes/ No

(If yes, name(s) of medication)

_____

- Serious injury or illness Yes/ No
- Alcohol use Yes/ No
- Drug use Yes/ No
- Smoked cigarettes Yes/ No
- Had fever, rash, infection or other illness Yes/ No
- Had X-Rays Yes/No
- Diabetes Yes/ No
- Other

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**C. Infant's Health at Delivery**

- Trouble breathing: Yes/ No
- Turned blue (cyanosis): Yes/ No
- Needed oxygen: Yes/ No
- Turned yellow (jaundice): Yes/ No
- Required phototherapy: Yes/ No
- Hospitalized after birth more than 7 days: Yes/ No

  Why? _____

  Birth defects: Yes/ No

  Jittery: Yes/ No

  Did your child require any special care shortly after birth? Yes/ No

  (If yes, please describe; e.g., blood transfusions, oxygen, incubator, medications, etc.)

_____

_____

_____

**D. Health During the Neonatal Period (first month):**

In the first month of life did your child experience:

Infections: Yes/ No

Gagging, choking or vomiting often: Yes/ No

Difficulty sucking or feeding: Yes/ No

Please explain below any other important information about your child's birth:

## Health/Medical History:

Who is your child's primary care doctor? _____

Please list the name, specialty, hospital or program affiliation, and address of any other physicians currently providing medical care to your child.

Physician's Name Specialty Hospital/Program Affiliation Address (if available)

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

List of current medical diagnoses:

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

Has your child ever been hospitalized? Please include any psychiatric hospitalization.

| Date | Reason | Length of Stay |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has your child had any of the following medical conditions? **Check if yes**.

| | | | | | |
|---|---|---|---|---|---|
| Speech/language problems | | Frequent abdominal pain | | Serious illness after immunizations | |
| Eye or vision problems | | Frequent or severe headaches | | Heart or blood pressure problems | |
| | | Chronic ear infections | | Asthma | |
| Hearing difficulties | | Pneumonia | | Seizures/ Neurologic Problems | |
| Fine Motor problems | | Meningitis | | Head injury or loss of consciousness | |
| Gross motor problems | | Kidney problems | | Motor/vocal tics | |
| Appetite or feeding problems | | Broken bones | | Sleeping problems | |
| Food allergies | | Bladder Problems | | | |
| Other allergies | | Bowel Problems | | | |

**If you checked yes to any of the above, please explain below:**

Is your child taking any medications on a regular basis? Yes/ No

Medications and condition the medication is treating:

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

Has your child ever been seen by a psychologist, psychiatrist, or counselor? Yes/ No
If yes, at what age and for how long? _____
What was the diagnosis? _____

Please indicate whether your child has ever been diagnosed with any of the following conditions:

| | | | | | |
|---|---|---|---|---|---|
| ADD, AD/HD | Yes/ No | Age at diagnosis | ____ | By whom | _____ |
| Learning disability | Yes/ No | Age at diagnosis | ____ | By whom | _____ |
| Depression | Yes/ No | Age at diagnosis | ____ | By whom | _____ |
| Anxiety | Yes/ No | Age at diagnosis | ____ | By whom | _____ |
| Autism/ Asperger's | Yes/ No | Age at diagnosis | ____ | By whom | _____ |
| Other Mental Health | Yes/ No | Age at diagnosis | ____ | By whom | _____ |

Please specify if other mental health diagnosis: _____

## **Developmental History:**

- At what age did your child:

| | | | |
|---|---|---|---|
| Sit without help? | _____ | Say single words meaningfully? | _____ |
| Crawl? | _____ | Combine 2 or more words? | _____ |

| | | | |
|---|---|---|---|
| Pull to a stand? | _____ | Combine 3 or more words? | _____ |
| Stand without help? | _____ | Use full sentences? | _____ |
| Cruise (walk holding on) | _____ | Use gestures to communicate? | _____ |
| Walking independently? | _____ | Use gestures with words? | _____ |
| Walk up/down stairs? | _____ | Show a hand preference? | _____ |
| | | Which hand? | _____ |

**If your child is 5 years of age and younger:**

- About how many words are in your child's vocabulary? _____
- How much of what your child hears, does he/she understand? _____
- How many steps in an instruction can your child follow? _____
- How much of what your child says, can *you* understand? _____
- How much of what your child says, can *others* understand? _____

- Is your child toilet trained? Yes/ No
  What age? _____

- Does your child have toileting accidents *during the day*? Yes/ No
  How often? _____

- Does your child have any toileting accidents *during the night*? Yes/ No
  How often? _____

- Does your child have sleeping difficulties? Yes/ No
  (i.e. Difficulty going to bed, falling and/or staying asleep?)
  Please describe: _____

- Does your child have any eating difficulties? Yes/ No
  Please describe: _____

- What toys or activities does your child seem to enjoy? _____
  _____

## Educational History:

- Did your child attend preschool? Yes/ No
  Age of Attendance(s):_____ School: _____
  Problems reported in Preschool: _____

- Did your child attend special needs preschool? Yes/ No
  Age of Attendance(s):_____ School: _____

- Age at Kindergarten entrance: _____School:_____

- Has your child ever repeated a grade? Yes/ No
  If yes, what grades? _____

- Has your child had a frequent change of schools? Yes/ No

- If yes, how many schools has he/she attended? _____

- Current grade placement: _____

- Name of Current School: _____

- Has your child received or is currently receiving any of the following services:

| | | Ages or Grades |
|---|---|---|
| Speech/language therapy | Yes/ No | _____ |
| Physical Therapy | Yes/ No | _____ |
| Occupational Therapy | Yes/ No | _____ |
| Learning Disabilities Tutoring | Yes/ No | _____ |
| Counseling | Yes/ No | _____ |

Others, please describe: _____

- Has your child ever been placed in any of the following special educational programs?

| | |
|---|---|
| Developmental Preschool | Yes/ No |
| Emotional Handicapped | Yes/ No |
| Intellectual Disability | Yes/ No |
| Learning Disabilities Resource room | Yes/ No |
| Multiple Handicapped | Yes/ No |
| Hearing Impaired | Yes/ No |
| Visually Impaired | Yes/ No |
| Other (specify): | Yes/ No |

_____

**If your child is 5 years of age and older and in school**, please indicate how your child is doing in each of these areas:

| | Serious Problem | Below Average | Average | Excellent |
|---|---|---|---|---|
| Reading | | | | |
| Spelling | | | | |
| Math | | | | |
| Writing | | | | |
| Behavior | | | | |
| Athletics | | | | |
| Attendance | | | | |
| Turning in assignments | | | | |
| Social or friends | | | | |

If appropriate, is your child involved in any vocational education? Yes/ No

- What do you enjoy most about raising your child?

- What do you find most difficult about raising your child?

## Additional Information

Please add any additional information that you believe will help us to better understand your child.

**Thank you for taking the time to complete this form. Please send this back along with any additional paperwork and reports, including previous evaluations (psychological/neuropsychological, IEP, 504, ARD paperwork, etc.).**

*Please note that while information sent from our secure email account is safe, we cannot guarantee the security of forms sent from your individual email account. By sending this document via electronic mail you are accepting responsibility for the transmission of this information online.*