Cardinal Pediatrics

Patient Name: _____ Date of Birth: _____

Caregiver completing form: _____ Date: _____

Specific Concerns w/ descriptions:

Speech delay: _____

Motor delay: _____

Behavior issues: _____

Other: _____

When did concerns begin: _____

Previous Medical Diagnoses: _____
(i.e. seizures, developmental delay) _

Previous testing / dates related to concerns:

☐MRIs/CT scan: _____ ☐Genetic Testing: _____

☐EEG: _____ ☐Developmental Testing: _____

☐Sleep study: _____ ☐Autism Specific Testing:_____

☐Other: _____ ☐Hearing Evaluation: _____

Current Medications (prescription or over the counter) - include name/dosage and frequency:

_____

_____

_____

Early Intervention/ Therapy Services - include services, location and beginning and ending dates:

☐Birth to Three: _____

☐Speech Therapy: _____

☐Occupational Therapy: _____

☐Physical Therapy: _____

☐ABA Therapy: _____

☐Other: _____

Primary Language used in home: _____ Interpreter needed for visit: YES / NO

Name of school or daycare: _____

Please list Special Accommodations, IEP or 504? _____

_____

_____

Cardinal Pediatrics

Patient Name: _____ Date of Birth: _____

PREGNANCY HISTORY

Maternal Age _____ Paternal Age _____ Number Pregnancy of this patient _____

Prev Miscarriages/Abortions _____

Problems during pregnancy: ☐ High blood pressure ☐ Gestational Diabetes ☐ Pre-eclampsia

☐ Other:_____

Medication use during pregnancy (Rx or OTC): _____

Drug/Alcohol use (incl substance and how often): _____

Delivery type ☐ Vaginal ☐ Scheduled C-Section ☐ Emergency C-Section Delivered at _____ weeks

Complications during Delivery: _____

Problems after delivery: ☐ Jaundice ☐ Trouble Breathing ☐ NICU Stay

☐ Other: _____

Birth Weight: _____ Length of Hospital Stay: _____

DEVELOPMENTAL HISTORY

When did patient start walking independently: _____

First word / Age: _____ How many words in current vocabulary: _____

Does child say 2+ words together to make a sentence: YES / NO

Can child follow simple verbal commands (i.e. bring me the blanket, go get your cup): YES / NO

Current concerns about motor skills: _____

Any vision concerns: _____

Any hearing concerns: _____

Has child ever lost any developmental skills (include skills/age): _____

_____

Previous Surgeries or Overnight hospitalizations: _____

_____

FAMILY HISTORY – please list relation: parent, siblings/half sibling, aunts/uncle, cousin, grandparent

YES / NO Developmental Delays: _____

YES / NO Learning Problems: _____

YES / NO Intellectual disability/Mental retardation: _____

YES / NO Seizures/epilepsy: _____

YES / NO Birth Defects: _____

(e.g. spina bifida, brain malformation, cleft palate/lip, club feet)

YES / NO Autism: _____

YES / NO Genetic Syndrome / Abnormal genetic test result: _____

YES / NO Bone or muscle problems: _____

Other significant medical history: _____

Cardinal Pediatrics

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Concerns about child's behavior from caregivers or teachers:

☐Aggression
☐Self injurious behaviors
☐Decreased interest in others
☐Unusual interests or obsessions
☐Trouble with changes in routine
☐Poor focus
☐Impulsive/ hyperactive behaviors
☐Repetitive body movements (hand flapping/toe walking)
☐Lack of Safety Awareness
☐Sensory Issues
☐Other: _____

_____

Any other specific concerns the family would like to discuss at the visit (i.e. sleep, potty training, feeding issues: _____

_____

Referred by: _____

In addition to the this completed form, please provide us the following information:

- **Medical records**
- **Immunization Records**
- If child attends school, please include:
  - **School Records**: IEP, 504 or Special Accommodation
  - Ask teacher to complete the **Teacher/Caregiver Questionnaire** – found online at www.cardinalpediatrics.com under Forms and Screeners

To send information:

- Securely email at www.cardinalpediatrics.com/securesend
- Fax to 304-599-8003
- Mail to 1247 Suncrest Towne Centre, Morgantown, WV 26505

To plan for your upcoming visit – check out our Autism page at www.cardinalpediatrics.com. It provides information on what to expect and available resources.