clarity
Discovering Potential
Empowering Communication
Transforming Lives

Initial Questionnaire: Medical, Family and Developmental History

The purpose of this *questionnaire is to gather information about your child and family before your child's evaluation. Your answers* will allow us to plan the evaluation specifically for your child. Do not worry if you do not have information to answer every question, as we will be discussing this further at your child's appointment. We appreciate your time and effort in completing this questionnaire. If you need additional space, please write on the back of the page.

GENERAL INFORMATION

Date: ______________ Form Completed By: ______________________________________

Relationship to Child: ____

Child's Name: ____
(First) (Middle) (Last) ("Nick Name")

Sex: ________ Birth Date: ______________ School Grade (If In School): ________________

Circle One: Adopted Biological Foster

At what age did the child come into the home (if not biological)? ________________________

Parent Name: ____ Phone #: __________________

Address: ____

Guardian Name (if different than parent): ______________________________________

Phone #: ______________________ Address: ______________________________________

Who recommended or referred your child for this appointment? ______________________

____

Who is your child's primary care physician? ___________________________________

What are the concerns you have about your child? ______________________________

____

____

When was this first noticed? ____

PREGNANCY, BIRTH AND HEALTH HISTORY

Number of pregnancies of child's biological mother: ______________________________

Has the mother had miscarriages, abortions, or stillbirths? (Please list):________________

____

During the pregnancy with the child, did the mother:

	Yes	No	Further Description of Problem
Experience infection or other illness	___	___	______________________
Have toxemia	___	___	______________________
Have bleeding	___	___	______________________

Have unusual physical strain or injury ___ ___ ______________________________

Have unusual emotional strain ___ ___ ______________________________

Drink alcoholic beverages ___ ___ ______________________________

(indicate how much)

Smoke (indicate how much) ___ ___ ______________________________

Take medication or drugs ___ ___ ______________________________
(other than vitamins/iron)

What other problems did the mother have? ____

Estimated length of pregnancy: ________________(weeks)

Birth weight: _______ lbs. _________oz. Apgar score, if known: ____________ & _______

Type of delivery (check one): Spontaneous_______ Cesarean_________ Forceps___________

Did baby need medical assistance to start to breathe? Yes_____ No_____

Was baby in the Neonatal Intensive Care Unit or other special care nursery? Yes ____ No _____

Check any of the following which baby had in the first month of life:

___Breathing problems ___Convulsions ___Skin Rash ___Excessive Vomiting

___Jaundice(yellow) ___Infection ___Birth Defect

___Excessive crying ___Injury ___Feeding Difficulty

What were your first impressions of your baby? ____

How long did your baby stay in the hospital after birth? __________________________________

Did the baby require any other special treatment at time of birth? Yes_____ No_____

Describe: ____

Did your child pass their newborn hearing screening Yes No Don't know Not screened

Has the child had any of the following?	Yes	No	Ages
1. Convulsions, seizures, fainting spells	___	___	_______
2. Vision or eye problems	___	___	_______
3. Ear infections	___	___	_______
If yes, how many? _______			
4. Hearing problems	___	___	_______
5. Allergies	___	___	_______
If yes, what is child allergic to? ____			
6. Any serious accidents or injuries?	___	___	_______
7. Any poisoning or overdose?	___	___	_______
8. Any problems of weight gain or loss?	___	___	_______

29 North Academy Street Greenville, SC 29601 (864)331-1400 FAX (864)331-1416

*Child's name*______________________
*Child's DOB*_________________________

9. Was child ever hospitalized overnight? ___ ___ _______
   If yes, when and why? ____
10. Any other chronic or serious health problems? ___ ___ _______
11. Any history of lead poisoning or other toxin exposure? ___ ___ _______
12. Any reaction to an immunization? ___ ___ _______
13. Has child had a medical check-up within the past 12 months? Yes_______ No_______

If any health problems or recommendations, what/by whom? ______________________________

____

What medications is your child presently taking? ____

14. Has the child ever been given a diagnosis for a developmental or other health-related problem?

If so, please state: ____

____

FAMILY HISTORY

Mother: Age and General Health: ____

School level completed: _________ Present occupation: ________________________________

Father: Age and General Health: ____

School level completed: _________ Present occupation: ________________________________

Brothers and/or Sisters:

Name:	Age:	Health and Development:
______________________	______	______________________
______________________	______	______________________
______________________	______	______________________

Are any siblings deceased? Yes ______ No ______

Are the child's parents related in any way except marriage? Yes _______ No _______

Note below if any of the child's relatives (parents, brothers, sisters cousins, aunts, uncles, grandparents) have had any of the following conditions (*please indicate which relative next to lines checked*):

___ Hyperactivity/attention problems
___ Epilepsy (convulsions, blackouts, seizures)
___ Mental disabilities
___ Cerebral palsy
___ Diabetes or hypoglycemia
___ Hearing loss (not caused by age or noise)
___ Kept back in school
___ Other chronic physical illnesses
___ Speech and/or language problems
___ Drug/alcohol abuse
___ Mental illness or emotional problems
___ Learning disabilities
___ Problems in mathematics
___ Behavioral problems

___ Muscular problems/weakness
___ Physical deformities
___ Vision problems
___ Genetic disease
___ Heart disease/heart attack (before 40)
___ Brain/spinal cord damage
___ Other: ____

Have there been any recent changes or stresses in the family/home? Yes _____ No _____

Explain: ____

____

DEVELOPMENTAL HISTORY

Please comment on when your child did the following things:

Action	Time (please circle)	Approx. age (please write)
Roll over (tummy to back)	seemed early / seemed on time / seemed late	
Roll over (back to tummy)	seemed early / seemed on time / seemed late	
Sit up with support	seemed early / seemed on time / seemed late	
Sit up without support	seemed early / seemed on time / seemed late	
Crawl	seemed early / seemed on time / seemed late	
Pull up to stand on furniture	seemed early / seemed on time / seemed late	
Walk alone	seemed early / seemed on time / seemed late	
Give up his/her bottle	seemed early / seemed on time / seemed late	
Drink from sipper top cup	seemed early / seemed on time / seemed late	
Drink from regular cup	seemed early / seemed on time / seemed late	
Finger feed self	seemed early / seemed on time / seemed late	
Feed self with a spoon	seemed early / seemed on time / seemed late	
Dress self	seemed early / seemed on time / seemed late	
Undress self	seemed early / seemed on time / seemed late	
Achieve toilet training for bladder	seemed early / seemed on time / seemed late	Day: _______ Night: _______

*Child's name*____________________
*Child's DOB*____________________

Achieve toilet training for bowels	seemed early / seemed on time / seemed late	Day: _______ Night: _______
Smile	seemed early / seemed on time / seemed late	
Coo	seemed early / seemed on time / seemed late	
Babble (da-da-da, ba-ba-ba)	seemed early / seemed on time / seemed late	
Jargon (talk in own special language)	seemed early / seemed on time / seemed late	
Say single words	seemed early / seemed on time / seemed late	
Begin to use phrases (ex. "more juice")	seemed early / seemed on time / seemed late	
Begin to use short sentences	seemed early / seemed on time / seemed late	

SCHOOL HISTORY

Where does your child attend daycare, preschool, or school? ____________________________________

Has your child repeated a grade? Yes ___________ No _________ Which one?____________________

Is your child receiving extra school help? Yes _____ No _____

If yes, please check which kind: Tutoring _____ Counseling _____ Other (list) _______

____

Has your child had learning problems: In preschool or kindergarten?______________________________

elementary school? ________ middle school? _______ high school? _______

Has your child ever received Special Education services? Yes_______ No __________

Which grade(s)? ____

Does your child receive physical, occupational or speech therapy in school? Yes _______ No _____

Does your child currently have an Individualized Education Plan (IEP)? Yes _________ No _____

Describe any current school problems: ____

____

Are there behavior problems in school? Yes ____________ No ________

If yes, please list: ____

Does your child have friends at school? Yes ____________ No ________

What does your child do after school? ____

*Child's name*______________________
*Child's DOB*_______________________

Behavior Checklist

If your child is 5 years or younger, please complete "A" - The Child Behavior and Temperament Profile. If your child is 6 or older, please complete "B" - The Pediatric Symptom Checklist.

A. The Child Behavior and Temperament Profile (children under 5). The following list of behaviors and functional problems occur in many children at different times in their lives. Please evaluate your child in reference to these behaviors on a scale of 1 to 5 with a 1 being "no problem" and a 5 being a "severe problem." If it was a problem in the past, please indicate the age.

		No problem				Severe	Age
1.	Eating/stomach problem	1	2	3	4	5	_____
2.	Colicky infant	1	2	3	4	5	_____
3.	Difficult to satisfy	1	2	3	4	5	_____
4.	Trouble with sleeping/nightmares	1	2	3	4	5	_____
5.	Overactivity	1	2	3	4	5	_____
6.	Temper tantrums	1	2	3	4	5	_____
7.	Unusual fears/phobias	1	2	3	4	5	_____
8.	Destructive behavior/hurts self	1	2	3	4	5	_____
9.	Easily frustrated with tasks	1	2	3	4	5	_____
10.	Irritable	1	2	3	4	5	_____
11.	Stubborn	1	2	3	4	5	_____
12.	Poor concentration/short attention	1	2	3	4	5	_____
13.	Not affectionate/poor eye contact	1	2	3	4	5	_____
14.	Difficult to discipline	1	2	3	4	5	_____
15.	Angers easily/strikes out at others	1	2	3	4	5	_____
16.	Acts without thinking	1	2	3	4	5	_____
17.	Cruel to animals	1	2	3	4	5	_____
18.	Tells lies	1	2	3	4	5	_____
19.	Poor self-esteem	1	2	3	4	5	_____
20.	Worries a great deal	1	2	3	4	5	_____

21. Other behaviors of concern:

____

____

*Child's name*______________________
*Child's DOB*______________________

B. The Pediatric Symptom Checklist (children 6 and older). Please mark under the heading that best fits your child:

		Never	Sometimes	Often
1.	Complains of aches and pains	_______	_______	______
2.	Spends more time alone	_______	_______	______
3.	Tires easily, little energy	_______	_______	______
4.	Fidgety, unable to sit still	_______	_______	______
5.	Has trouble with teacher	_______	_______	______
6.	Less interested in school	_______	_______	______
7.	Acts as if driven by a motor	_______	_______	______
8.	Daydreams too much	_______	_______	______
9.	Distracted easily	_______	_______	______
10.	Is afraid of new situations	_______	_______	______
11.	Feels sad, unhappy	_______	_______	______
12.	Is irritable, angry	_______	_______	______
13.	Feels hopeless	_______	_______	______
14.	Has trouble concentrating	_______	_______	______
15.	Less interest in friends	_______	_______	______
16.	Fights with other children	_______	_______	______
17.	Absent from school	_______	_______	______
18.	School grades dropping	_______	_______	______
19.	Is down on him/herself	_______	_______	______
20.	Visits doctor with finding nothing wrong	_______	_______	______
21.	Has trouble with sleeping	_______	_______	______
22.	Worries a lot	_______	_______	______
23.	Wants to be with you more than before	_______	_______	______
24.	Feels he/she is bad	_______	_______	______
25.	Takes unnecessary risks	_______	_______	______
26.	Gets hurt frequently	_______	_______	______
27.	Seems to be having less fun	_______	_______	______
28.	Acts younger than children his/her age	_______	_______	______
29.	Does not listen to rules	_______	_______	______
30.	Does not show feelings	_______	_______	______
31.	Does not understand other people's feelings	_______	_______	______

*Child's name*______________________

*Child's DOB*_______________________

32.	Teases others	_______	_______	______
33.	Blames others for his/her troubles	_______	_______	______
34.	Takes things that do not belong to him/her	_______	_______	______
35.	Refuses to share	_______	_______	______

Please list things your child does well:

____

____

____

What are the most positive features about your child?

____

____

____

How does your child fit in at home with other family members?

____

____

____

What do you feel caused your child's problem?

____

____

____

If you have any additional comments, please write them below.

Thank you very much for spending time filling out this questionnaire.

29 North Academy Street Greenville, SC 29601 (864)331-1400 FAX (864)331-1416

*Child's name*______________________

*Child's DOB*___ ____________________

Patient History

Patient Name ________________________________ Date of Birth ________ Today's Date ______________

Referring Physician ____________________________________ Physician Phone Number _______________

What is your primary reason for this visit: ____

Are you concerned about your child's hearing?____

Are you concerned about your child's speech?____

Is there a family history of hearing loss?____

Is there a family history of speech delay?____

Has this child had frequent ear infections?_____________________________ Date of last episode ____________

Were there any complications at time of birth?____

Weeks of gestation _____________________ Birth Weight_____________________ Apgar Score_______________

Were there health complications during the first months of life?_______________________________________

Were any of the following present:

NICU or longer than normal hospital stay _______ Jaundice________ No response to sound ___________

Infection at birth ________ In an incubator___________ Use of mechanical ventilator__________________

Physical abnormalities____ High fevers or seizure___________

Did your child pass the newborn hearing screening ____

What ages did your child: Sit alone_________________ Walk ________________ Say first word _____________

Is your child diagnosed with a genetic disorder or developmental delay? Please explain.

____

____

Has your child any history of head injuries, major illness, high fevers or hospitalizations?_________________

Is your child taking any medication of a regular basis?____________ List medications

____

*Child's name*______________________

*Child's DOB*______________________

General Financial Policies

Insurance Disclosure

Please read and sign the following. If you have any questions about this form, please call (864) 331-1400.

I understand that I am responsible for contacting my Insurance Company or Primary Care Physician for authorization of any visits to Clarity before my appointment date. I understand that prior authorization by my insurance company is not a guarantee of payment, and that I am responsible for all costs not covered by my Insurance Company. These costs include, but are not limited to: services provided which are not covered by my policy, balances after insurance payment, or failure to obtain authorization before my appointments. I understand that I may be required to pay all amounts owed at the time services are rendered.

If there are any changes to your or your child's insurance between now and the time of your appointment, please notify us because your new insurance may not cover your service.

__________________________________ ______________________________
Signature of Patient or Parent/Guardian Date

__________________________________ ______________________________
Patient's Name Patient's Date of Birth

I authorize the release of any medical or other information to the insurance company that is necessary to process my insurance claim(s).

__________________________________ ______________________________
Signature of Patient or Parent//Guardian Date

Late Cancellation and no-show policy:

If for any reason, you are unable to keep this appointment, we request you call us 24 hours in advance at 864-331-1400 to cancel or reschedule. If **two** appointments (in any six month time period) are missed or cancelled with less than 24 hours notice, we will reschedule the appointment **after** a six month waiting period from the time of the missed appointment.

I acknowledge that I understand the late cancellation and no-show policy.

__________________________________ ______________________________
Signature of Patient or Parent//Guardian Date

*Child's name*______________________
*Child's DOB*_______________________

Directions to the Center for Developmental Services
29 North Academy Street Greenville, SC 29601
(864) 331-1300

From Anderson
- Take I-85 to Exit 42 in Greenville (I-185)
- Take I-185 into Greenville (2.4 miles)
- I-185 becomes Mills Ave./29
- Drive 1 mile on Mills Ave. to Augusta St./25
- Turn left onto Augusta St.
- Drive about 1 mile to intersection of Pendleton, River, Main, and Augusta Streets -- veer left onto River St.
- Turn left onto Camperdown Way
- Turn right onto Academy St.
- Cross McBee Ave. and Washington St.
- Building is on the left on the corner of Hampton and Academy Streets

From Spartanburg:
- Take I-85 to I-385 North
- Merge onto I-385 North via Exit 51
- I-385 becomes East North St. as you approach downtown
- Take a right on Academy St. and drive 1.1 miles
- Building is on the right on the corner of Hampton and Academy Streets

From Easley:
- Take U.S. 123 N. to Greenville
- Becomes Easley Bridge Highway/U.S. 123 N.
- Cross Pendleton St. -- becomes S. Academy St./U.S. 123 N.
- Drive about 1.3 miles -- cross Washington St.
- Building is on the left on the corner of Hampton and Academy Streets

From Greer:
- Take Wade Hampton Blvd./U.S. 29 S. to Greenville
- Veer left onto Church St.
- Turn right onto Academy St.
- Cross Buncombe St. -- drive one block
- Building is on the right on the corner of Hampton and Academy Streets

From Laurens and the Golden Strip area:
- Take I-385 into Greenville
- Cross Church St./U.S. 29 (pass Bon Secours Wellness Arena, formerly Bi-Lo Center) - - street name becomes Beattie Pl.
- Cross Main St. -- street name becomes College St.
- Turn left onto Academy St.
- Building is on the right on next block on the corner of Hampton and Academy Streets

From Travelers Rest:
- Take Poinsett Highway/U.S. 276/U.S. 25 south to Greenville
- Becomes Rutherford St.
- Turn left onto Buncombe St.
- Drive a half mile -- turn right onto Academy St.
- Building is on the right on the next block on the corner of Hampton and Academy Streets

*Child's name*______________________
*Child's DOB*_________________________