Bloom Pediatrics

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General Information:

Client Name: _____ Date of Birth: _____ Age: _____

Gender: F M Primary Language: _____ Other Languages: _____

Please list any sibling's names/ages: _____

How did you hear about us? _____

Parent/Guardian Information (Please list all):

Name: _____ Relationship: _____

Phone: _____ Email: _____

Street Address: _____

City: _____ Zip Code: _____

Name: _____ Relationship: _____

Phone: _____ Email: _____

Street Address: _____

City: _____ Zip Code: _____

Insurance Information:

Insurance Company: _____ Insurance Type: PPO HMO POS

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

ID Number: _____ Group Number: _____

Customer Service Phone Number Listed on Card: _____

Family Concerns:

Please list your primary concerns or goals that you have for your child: _____

_____

_____

When did you first become concerned about your child's development? _____

_____

_____

What specific areas of development are causing concern? Please check yes/no:

Developmental Area	**Yes**	**No**
Hearing		
Vision		
Ability to calm themselves		
Sleeping		
Motor Planning		
Motor Control		
Activities of Daily Living		
Mobility		
Play		
Transfers		
Motivation		

Developmental Area	**Yes**	No
Speech/Language		
Social Interaction		
Behavior		
Tantrums		
Nutrition		
Eating/Feeding		
Hand Use		
Positioning		
Sensory Integration/Regulation		
Touch		
Attention		

PREGNANCY/DELIVERY

Were there any complications during pregnancy, labor, or delivery? If so, please specify:

_____

_____

_____

Medications given during pregnancy, labor, and delivery: _____

_____

Describe child's condition at/or immediately after birth: Premature ___ (If Yes) Gestational Age _____

NICU ___ (If Yes) How long _____ Jaundice ____ Heart Problems ____

Ventilator ___ (If Yes) How long _____ Poor Suck/Latch ____ Tongue/Lip Tie ____ Cleft Palate___

Does your child have any current diagnoses or syndromes or are there suspected diagnoses or syndrome(s) (e.g. Down Syndrome, Autism)? _____

_____

MEDICAL HISTORY

Has your child ever been evaluated by a specialist (neurologist, psychologist, ENT, etc.)? Yes No

If yes, please specify:

_____

Has your child ever received speech, occupational, and/or physical therapy? Yes No

Has your child's hearing been evaluated since the newborn hearing screening? Yes No

If yes, results: _____

Has your child had frequent ear infections? Yes No If yes, about how many in the last 12 months? _____

Has your child had PE tubes placed or other ear surgeries? Yes No If so, when?

_____

Does your child wear a hearing aide? Y N

Has your child ever had a vision test? Y N

If yes, date and results: _____

Does your child wear glasses? Y N

Please list current medications: _____

_____

Please name any current vitamins, herbs, minerals, or homeopathic measures you are taking with your child:

_____

_____

Does your child have any known allergies? _____

_____

Please describe illnesses, hospitalizations, and/or surgeries/procedures that your child has had and when they occurred: _____

_____

DEVELOPMENTAL MILESTONES

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following **INDEPENDENTLY**. Or, if you cannot recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time, or late. If your child has not yet achieved the milestone, write N/A in the age column. Please also check the column that best describes your opinion of the quality of your child's skills.

AGE ACHIEVED	MILESTONE	EARLY	ON TIME	LATE	SKILL QUALITY GOOD/FAIR	SKILL QUALITY POOR
	Smiled					
	Held head up					
	Rolled over					
	Reached for an object actively					
	Transferred object between hands					
	Sat unsupported					
	Crawled					
	Stood alone					
	Walked by self					
	Said first words					
	Threw objects actively					

	Ran by self					
	Followed simple 1 step directions					
	Said 2-3 word phrases					
	Ate unaided with a spoon/fork					
	Dressed self					
	Chewed solid food					
	Drank from an open cup					
	Rode bicycle without training wheels					
	Caught a thrown object					
	Demonstrated handedness (which?)					
	Knew colors					
	Counted to 5					
	Knew alphabet					
	Potty trained					

Was your child's crawling phase brief? _____No _____Yes

Please describe the position your child crawled in (i.e. four point, army crawl, scooted on bottom):_____

_____

Did your child use a walker (rolling plastic seat)? _____No _____Yes If so, how often? _____

Did your child experience hesitancy or delays in learning to go down stairs? _____No _____Yes

Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain: _____

_____

SPEECH AND LANGUAGE DEVELOPMENT

Did your child begin speaking in single words, then two words, then a sentence? _____No ____Yes

Did your child not talk for a long while, then all of a sudden speak in complete sentences? _No __Yes

Do you or others have difficulty understanding what your child says? _____No _____Yes

First word he/she said was, _____, at the age of_____

Please describe any speech related problems:_____

_____

_____

Is there a family history of speech language or other developmental delay? Y N

If yes, please describe: _____

_____

_____

FEEDING

Is your child a picky eater? Y N If yes, please explain: _____

_____

_____

Does your child dislike certain textures of food? Y N If yes, please list: _____

_____

_____

Does your child have any difficulty with the following:

Poor Suck_____ Difficulty Swallowing_____ Gag/choke often_____ Finger Feeding____

Spoon Use_____ Reflux/vomiting_____

Did your child require a feeding tube? Y N If yes, when and for how long?_____

_____

_____

SENSORY and MOTOR DEVELOPMENT

MY CHILD	**YES**	**SOMETIMES**	**NO**
Overreacts or does not like touch, noise, smells, lights, etc.			
Prefers activities such as rough housing, pushing, wrestling, climbing, spinning, jumping, etc.			
Bumps into things and/or trips often			
Has difficulty with handwriting, fastening buttons, coloring, drawing, snaps, opening packages (i.e. milk, fruit snacks)			
Avoids new foods/has a limited range of preferred food			
Avoids certain textures (mushy, slimy, crunchy, chewy)			
Prefers certain textures (mushy, slimy, crunchy, chewy)			
Prefers clothes, shoes, or accessories that are very tight or very loose			
Overreacts/avoids getting hands, face, clothing messy			
Touches everything/gets into others space often			
Hums, makes inappropriate noises			
Is constantly moving			

Do any of the following behaviors describe your child currently or in the past? Please indicate by placing a checkmark in the “no” or “yes” column and if yes please explain/comment.

NO	**YES**	**DESCRIPTION**	**EXPLANATION**
		Thumb sucking/pacifier	Until what age?
		Sleeping Problems (falling/staying asleep)	
		Colic or “fussy baby”	
		Able to self soothe	
		Prefered certain positions as an infant	What positions?
		Dislikes lying on stomach	
		Dislikes lying on back	
		Calmed by motion (car rides, infant swings, spinning)	

NO	YES	DESCRIPTION	EXPLANATION
		Nauseated by motion (car rides, spinning)	
		Toe Walker	Until what age?
		Excessive Drooling	For how long?
		Temper Tantrums	
		Head Banging	
		Breath Holding	
		Bedwetting	Until what age?
		Nervous habits (i.e. nail biting)	
		Major mood swings	
		Aggression/destructiveness	

EDUCATIONAL HISTORY

Grade: ____ Name of school: _____

Teacher: _____

What kind of classroom (i.e. regular ed, special ed, life skills, pull-outs, etc.): _____

Does your child have an IEP? YES NO

What services does your child receive at school? _____

Name of any school therapists: _____

****If your child has an IEP through his/her school, please bring a copy for our records****

****If your child has a neuropsych evaluation or and additional testing, please bring us a copy for our records****