WESTERN MICHIGAN UNIVERSITY
Homer Stryker M.D.
SCHOOL OF MEDICINE

Developmental-Behavioral Pediatric Clinic

- **Please answer the following questions to the best of your ability and bring this form to the visit.**

- **Please also bring ALL school, therapy, mental health records that you can to the visit.**

If you have questions about this form or have difficulty filling it out, please contact us at 269-337-6400

Child's name:	Child's date of birth:

Name of person completing form: _____

Relationship to child: ☐ biologic parent ☐ foster parent ☐ adoptive parent
☐ relative ☐ guardian

Why would you like your child to be seen?

_____

_____

_____

Who Lives at Home with this Child? (Please list all adults and children in the household)

Name	Age	Relationship to Child	Any Health or Mental Health issues this person may have?

Are there any living arrangements (for example, shared custody or foster care), custody issues, parental disagreement about care, or orders of protection that we should be aware of?

If "Yes", please describe:_____

_____

Does your child have any of the following medical concerns?

Concern	**No**,	**Yes**,	**If "Yes"**, please describe
Genetic Disorder			
Neurological Problems (Head Injury, Tics, Tremors, Seizures, Headaches)			
Eye or Vision Problem			
Ear or Hearing Problem			
Dental or Tooth Problem			
Heart Problem			
Breathing or Lung Problem, Asthma			
GI Problem: Vomiting/Reflux/Stomach Pain/ Diarrhea, Constipation			
Feeding Problem or Use of a Feeding Tube			
Kidney/Bladder/Genital Problems			
Bone, Joint, or Muscle Problems			
Anemia or Other Blood Problems			
Skin Rashes			
Endocrine or Hormone Problems			
Allergies			
Does your child use any adaptive equipment?			☐ Glasses/Hearing Aids ☐ Walker/Wheelchair ☐ Communication Device

What medicines, vitamins and nutrition supplements does your child take each day?

Medicine Name Vitamin/Supplement Name & Brand	**Dose (how many mg, how often)**

Has your child been admitted to the hospital overnight or had surgery?

Age at Time of Hospitalization	**Reason**

Is your child up to date on immunizations? ☐ Yes ☐ No ☐ Unsure

Has your child had vision tested? ☐ Yes, at age_____ ☐ No ☐ Unsure

Has your child had hearing tested? ☐ Yes, at age_____ ☐ No ☐ Unsure

Pregnancy and Birth History

How many times has the birth mother been pregnant? _____

How many children does the birth mother have? _____

How many of those children are older than this child? _____

Did the birth mother…

Lose any pregnancies (have a miscarriage)? ☐Yes ☐No ☐

Terminate any pregnancies due to a health problem or genetic condition of the baby? ☐Yes ☐No ☐

Need treatment to become pregnant (fertility medicine, intrauterine insemination, IVF)? ☐Yes ☐No ☐

Receive prenatal care? ☐Yes ☐No ☐

Have any infections or fevers during the pregnancy? ☐Yes ☐No ☐

Have high blood pressure during pregnancy? ☐Yes ☐No ☐

Have diabetes during pregnancy? ☐Yes ☐No ☐

Have any other complications during pregnancy? ☐Yes ☐No ☐

If "Yes", please describe:_____

Used alcohol or other substances during pregnancy?

If "Yes", please describe: _____

Birth Mother's Age at Birth of Child_____**Birth Father's Age at Birth of Child** _____

Was this child… ☐ Single Birth ☐ One of Twins ☐ One of Triplets ☐Other Multiple

Was this child born by… ☐Vaginal Delivery ☐Cesarean Section

Were there any labor or delivery complications? ☐Yes ☐No

If "Yes", please describe: _____

Was the baby born early? ☐ Yes ☐ No ☐ Unsure

If yes, weeks early: _____

Birth Weight_____

Was your child admitted to the NICU (neonatal ICU)?

☐ Yes ☐ No ☐ Unsure

If "Yes", please describe: _____

Current Education

What grade is your child in?_____

Does your child receive any educational services? Yes No Unsure

Does your child have: ☐ Early Intervention Services ☐ AIS (Academic Intervention Services)

District-based Services IEP 504 Plan IFSP Unsure No Educational Supports

Services your child receives:

☐ Speech Therapy	☐ ABA/Autism Therapy	☐ Community Mental Health
☐ Physical Therapy	☐ Social Skills Training	☐ Other Counseling
☐ Occupational Therapy		