UTHealth The University of Texas Health Science Center at Houston | McGovern Medical School

CHILDREN'S LEARNING INSTITUTE

The Dan L. Duncan Children's Neurodevelopmental Clinic

FOLLOW-UP VISIT PATIENT INFORMATION FORM

Child's Legal Name:			Nickname?
Last Evaluated:	Date of Birth: ____-____-____	Age:___	Grade:___

Reason for re-evaluation: _____

_____

I. FAMILY INFORMATION: PLEASE UPDATE IF CHANGED

A. Parents

Parent's Name:		Age: ___	Parent's Name:		Age: ___
Address:			Address: (if different)		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:			Home Phone:		
Cell:			Cell:		
Email:			Email:		
Occupation:	Highest Degree:		Occupation:	Highest Degree:	
Year Married:	If Divorced, Year:		Year Married:	If Divorced, Year:	

B. Step Parents (if applicable)

Name:		Name:	
Occupation:	Highest Degree:	Occupation:	Highest Degree:
Year Married:	If Divorced, Year:	Year Married:	If Divorced, Year:

C. Other people child currently lives with (siblings, relatives):

Name	Age	Relationship to child (full, half, step sibling)

D. Family History

Check if yes. Relation to child: Sibling, parent, grandparent, aunt, uncle, cousin

	Relation		Relation
☐ ADD/ADHD		☐ Depression	
☐ Learning Disability (e.g., Dyslexia)		☐ Anxiety	
☐ Speech/Language Problems		☐ Bipolar Disorder	
☐ Autism Spectrum		☐ Alcohol/ Substance Abuse	
☐ Developmental Delay/ Intellectual Disability		☐ Sudden Cardiac Death/Cardiomyopathy	

A. Pregnancy History

Mom's age at Delivery ___	Mom total # Pregnancies ___	Patient was pregnancy #___	# of Miscarriages ___	# living Children ___

B. Medical Conditions during pregnancy with this child:

☐ Healthy, no problems Skip to C. If problems, complete below:

Type	Check if Yes	Month of Pregnancy	Description
Illness/Infections	☐		
Hypertension	☐		
Bleeding	☐		
Diabetes	☐		
Preterm labor	☐		
Exposure to toxic/X-ray	☐		
Medications	☐		
Alcohol/Cigarettes/Drugs	☐		
Other Problems	☐		

C. Labor and Delivery

Was baby Full Term? ☐ Yes ☐ No
If no, premature delivery occurred at _____ weeks of pregnancy.

Delivery was.... (Check all that apply below)

☐Vaginal	☐Head first	☐Breech
☐Forceps/ Vacuum	☐C-Section, Scheduled	☐C-Section, Emergency

Birth Weight: lbs. ozs.		Length: inches
Apgar Scores: 1 min: 5 min	Days in Hospital:	Head Circumference:

D. Neonatal History ☐ Normal Skip to E. If problems, complete below:

	Check If Yes		Check If Yes
Needed help breathing?	☐	Had brain hemorrhage?	☐
Had jaundice during first week?	☐	Had seizures?	☐
Had surgery shortly after birth?	☐	Had difficulty feeding (sucking, swallowing)?	☐
Other problems:			

E. Developmental History

Skill/Milestone	Age in months when achieved	Comments?
Slept through the night		
Sat alone		
Crawled		
Stood alone		
Walked alone		
Pedaled tricycle		
Rode bicycle without training wheels		
Said first word (other than "mama" or "dada")		
Spoke in simple phrases		
Spoke in mostly complete sentences		
Completed daytime toilet-training		
Completed nighttime toilet-training		

III. EDUCATIONAL HISTORY SINCE LAST EVALUATION

A. Current grade ____

	School Name	Type of Class: Regular, G/T, Special Education, 504
Elementary		
Middle		
High School		

If retained in any grades, please describe: _____

B. Specialized Services Since Last Visit

Has your child received testing or intervention services at school for a disability?

☐ **No If no, skip to D. If yes, please complete.**

Testing—what were results?	
What services/accommodations is child receiving now?	
Qualifying conditions:	☐ Speech ☐ LD ☐ Autism ☐ Other Health ☐ Behavioral ☐ 504

C. Community Interventions

Has your child received interventions in the community? ☐ **No; skip to V. If yes, complete below.**

Type of service	Ages received	Outcome?
Speech therapy		
Occupational therapy		
Physical therapy		
Developmental teaching		
Applied Behavioral Analysis (ABA)		
Tutoring		
Psychological therapy		
Other		

IV. FAMILY STRESSORS: List any stressors that your child/family has experienced in the past two years (e.g., death of pet, death/illness of family members, school performance issues, financial stresses):

V. ANYTHING ELSE? If there is anything else that you feel is important for your clinician to know about your child or your family, please describe below. _____

Form completed by: _____ **Relation to Child:** _____

INSURANCE INFORMATION FORM

This Information is helpful to us but is not a requirement unless we have an agreement in place with a contracting agency such as Kelsey-Seybold. In that case you must complete all information before we can schedule.

PATIENT INFORMATION

Full Name (please print): _____ Date of Birth: _____ Sex (circle): M F

INSURANCE INFORMATION

ID Number of the Insured Party: _____ Group Number _____

Insured's Name: _____ Sex (Circle): Male Female

Insured's Address: _____

_____

Home Telephone Number: _____ Other Number: _____

Insured's Date of Birth: _____ Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Complete Claims Address: _____

_____

Insurance Plan Telephone Number: _____

Patient Relationship to Insured (circle): Child Self Other

YOU MUST SIGN ONE OF THE FOLLOWING STATEMENTS

I hereby attest that the above policy is the only insurance coverage available to the patient described and that no co-benefits are available from a source.	
I hereby attest that there is additional coverage available to the patient described and that information is provided below.	

SECOND INSURANCE POLICY/CO-BENEFITS

ID Number of the Insured Party: _____ Group Number _____

Insured's Name: _____ Sex (Circle): Male Female

Insured's Address: _____

_____

Home Telephone Number: _____ Other Number: _____

Insured's Date of Birth: _____ Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Complete Claims Address: _____

_____

Insurance Plan Telephone Number: _____

Patient Relationship to Insured (circle): Child Self Other

REFERRING DOCTOR

Full Name: _____

Address: _____

Telephone Number: _____