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
PATIENT INFORMATION FORM

Child's Legal Name:			Nickname?
Sex: ☐ Male ☐ Female	Date of Birth: __ - __ - __	Age:___	Grade:___
Adopted? ☐ No ☐ Yes, at age_____		Ethnicity:	Language(s) spoken in home:

Who referred you to our clinic? _____

Reason for the evaluation: _____

_____

I. FAMILY INFORMATION

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

C. Brothers and Sisters

Name	Sex	Age	Where living, if out of child's home	Relationship to child (full, half, step)

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. MEDICAL HISTORY of CHILD

A. Illnesses/Injuries ☐ Healthy Skip to B. If problems, complete below:

	Check if Yes	If yes, Age		Check if Yes	If yes, Age
Chronic ear infections	☐		Heart Problems	☐	
Recurrent Strep Throat	☐		IBD/Celiac/GERD	☐	
Asthma	☐		Cancer	☐	
Allergies	☐		Other Illnesses	☐	
Dizziness/fainting	☐		Head Injury/concussion	☐	
Seizures//Epilepsy	☐		Other Illnesses or Injuries	☐	
Describe any health concerns:					

B. Surgeries

Type	Age	Complications/Results

C. Behavioral Health Diagnosis

	Check if Yes	If yes, Age		Check if Yes	If yes, Age
Anxiety	☐		Developmental Delay	☐	
Depression	☐		Fine or Gross Motor Delay	☐	
Bipolar Disorder	☐		Autism Spectrum	☐	
ADD/ADHD	☐		Tourette's or Tic Disorder	☐	
Learning Disorder	☐		Speech or Language Delay	☐	

D. Vision & Hearing

	Year	Results?	
Last vision check?			**Wear glasses?** ☐ **Yes** ☐ **No**
Last hearing check?			**Hearing aid?** ☐ **Yes** ☐ **No**

E. Medication History

List prescription medication child has taken on a regular basis (i.e., stimulants, antidepressants, anticonvulsants):

Medication	Dose	Reason for Medication	Currently taking? (circle one)
			Yes/No
			Yes/No
			Yes/No

IV. EDUCATIONAL HISTORY

A. Childcare/Preschool:

Complete section if child age 7 or less. If child is 8 years or older, skip to B

Has your child ever attended infant/toddler childcare, Mother's Day Out, or Pre-K?

☐ Yes ☐ No **If yes, please complete below:**

Name of School/Childcare/MDO/Pre-K	Ages attended	Reason for leaving

B. Grade School: Current grade____

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

If retained in any grades, please describe: _____

C. Specialized Services

Has your child ever received services at school for a disability? ☐ **No If no, skip to D**

☐ Yes ☐ No **Early Intervention Services (birth – 3yrs.)?**
☐ Yes ☐ No **Preschool Programs for Children with Disabilities (ages 3-5)**
☐ Yes ☐ No **Testing or intervention services (ages 6 + yrs.)?**

Qualifying conditions:	☐ Speech ☐ LD ☐ Autism ☐ Other Health ☐Behavioral ☐ 504
What services/accommodations is your child receiving now?	

D. Community Interventions

Has your child ever received interventions in the community? ☐ **No If NO, skip to V**

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

V. 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):

VI. 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:** _____

Authorization to Disclose Protected Health Information FORM

W. Daniel Williamson, M.D.
Dan L. Duncan Children's Neurodevelopmental Clinic Children's Learning Institute
University of Texas Health Science Center at Houston
6655 Travis, Suite 880 Houston, Texas 77030

This form is to confirm your authorization to disclose your child's protected health information to his/her pediatrician of record. You may request non-release with this form by writing "none" in the "This information may be disclosed TO... "paragraph below.

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name (first, middle, last and nickname): _____

Date of Birth: _____

I authorize the following to disclose the above individual's health information:

☐ W. Daniel Williamson, M.D. Developmental Pediatrician
6655 Travis, Suite 880
Houston, Texas 77030

This information may be disclosed TO my child's pediatrician:

Name: _____

Address: _____

_____

Purpose of disclosure: To share medical records.

Please release the following:

	Medical Evaluation report
	Laboratory Results
	Others specified:

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient/patient representative is prohibited.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of protected health information described in this form with the people and/or organizations named in this form. If I have questions about disclosure of my health information, I may contact Katrina Bright, Office Manager/Privacy Official, for Developmental Pediatric Associates.

Patient or Parent's/Guardian's Signature: _____

Patient or Parent's/Guardian's Printed Name: _____

Relationship to Patient: Date: _____

We do NOT share our records with any school or any other professional without your specific separate authorization to do so, that authorization will be obtained if/when necessary. If you choose, you may complete that authorization at the time of the parent conference or after you have reviewed the report, you will receive an exact copy of the original report that you can copy and share as you wish.

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: _____