

# Jordan Developmental Pediatrics



TODAYS DATE: \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Sex: M or F** \_\_\_\_\_

Mother's Name \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_ Email \_\_\_\_\_

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Father's Name \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_ Email \_\_\_\_\_

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Other Children in our Practice: Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Pediatrician's Name: \_\_\_\_\_ Practice Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

In Case of Emergency Please Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Please Describe The Current Problems or Issues

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- 
- 
1. Ability to understand words or stories that he/she hears?.....Excellent/Good/Fair/Poor
  2. Ability to use words and language to communicate w/ others?..... Excellent/Good/Fair/Poor
  3. Ability to remember words/phrases that he/she has been told?.....Excellent/Good/Fair/Poor
  4. Ability to remember things he/she has seen?..... Excellent/Good/Fair/ Poor
  5. Ability to remember details, names, or dates from the past?..... Excellent/Good/Fair/Poor
  6. Ability to put together puzzles, figure out how things work?.....Excellent/Good/Fair/Poor
  7. Ability to use his/her hands to eat, dress, draw, or write?..... Excellent/Good/Fair/Poor
  8. Ability to run, throw, and play outdoor games or sports?.....Excellent/Good/Fair/Poor

**Does your Child have Difficulties in the Following Areas?**

- Activity Level***- Amount of physical motion each day?.....Very Active/Average/Inactive
- Rhythmical*** - Regularity of sleep, hunger, bowel movements?..... Irregular/Somewhat/Regular
- Approach*** - Responses to new people, places, or events?..... Very resistant/Average/Not Resistant
- Adaptability*** - Ability of child to change his/her behavior to become acceptable?.....Slow to Adapt/ Average/ Quick to Adapt
- Intensity*** - Amount of energy in response to things?.....Intense/Average/ Mild
- Mood***- Amount of pleasant/unpleasant feelings?.....Unpleasant/Average/Pleasant
- Attention Span*** - How long your child stays on task/activity?.....Non Persistent/Average/Very Persistent
- Distractibility*** - To sounds, sights, people, behavior, affects task completion?.....Easily Distracted/Average/Not Distracted
- Threshold*** - Sensitivity to sounds, order, taste, lights, etc?.....Very sensitive/Average/Not Reactive

**Please answer the following questions about your child to the best of your ability**

1. How well your child gets along with other people?..... Excellent/Good/Fair/Poor
2. How well does your child perform task in school/sports?..... Excellent/Good/Fair/Poor
3. How does your child feel about his/her self esteem?..... Excellent/Good/Fair/Poor
4. Is your child anxious, depressed, have obsessive thoughts?.....Often/Sometimes/Never
5. Is your child good at solving problems?..... Excellent/Good/Fair/Poor
6. Does your child have any problems with physical functioning?.....Often/ Sometimes/ Never  
(eating, sleeping, tics, nail biting, etc.)

**Has your child ever been evaluated?** Yes / No

If yes, by whom? When? \_\_\_\_\_

What was the result or diagnosis? \_\_\_\_\_

What treatment was recommended? \_\_\_\_\_

Was the treatment done? Yes / No

**Are there any problems with your child's physical health? If yes, please explain:**

1. Nervous System (seizures, tics, muscle weakness, ect.) \_\_\_\_\_

2. Serious Long Term Problems (heart disease, asthma) \_\_\_\_\_

3. Serious Injuries or Operations (concussion, hernia) \_\_\_\_\_

4. Medications used for more than two weeks \_\_\_\_\_

5. Problems with vision or hearing (abnormal vision or hearing test) \_\_\_\_\_

6. Other medical problems \_\_\_\_\_

Gestation age at delivery (full-term gestation is 40 weeks) \_\_\_\_\_ Weeks. Birth Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz

Describe any problems with the pregnancy or delivery: \_\_\_\_\_

\_\_\_\_\_

***If any of the child's relatives have a diagnosis named below, circle and indicate relationship***

1. Mental retardation, Bi-polar, schizophrenia, autism: Relationship: \_\_\_\_\_

2. Anxiety, depression, alcohol or drug abuse: Relationship: \_\_\_\_\_

3. Learning problems (dyslexia, attention): Relationship: \_\_\_\_\_

4. Other mental health, neurological/developmental problem: Relationship: \_\_\_\_\_

Is the child's family having financial stress? Yes / No

Is the family having personal relationship problems that may cause stress? Yes / No

Has the child been sexually or physically abused or witnessed domestic violence? Yes/ No

If yes, to any of these questions, please describe: \_\_\_\_\_

Is there any other information regarding the child that could help with the evaluation?

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Jordan Developmental Pediatrics  
No Show Policy**

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

As a courtesy our office gives reminder calls 24 hours before an appointment. **Please verify your contact information with the front office to ensure receipt of this call.**

If you need to reschedule or cancel an appointment, we require a minimum of 24hrs notice. Please call the office at 602-956-3141.

“No shows” leave empty appointment times, as well as other patients waiting to receive medical care. For that reason, patients that do not honor their appointments will be charged a no show fee as follows:

**Effective 7/20/11**  
**The no-show fees are as follows:**  
**Commercial Insurance New Patient: \$50.00**  
**Commercial Insurance Follow up: \$25.00**

We thank you for working with us to ensure services are provided to you in the best possible way. - JDP

**Acknowledgement of No Show Policy**

**Patient:** \_\_\_\_\_

**Responsible Party Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_