CIVITAN-SPARKS CLINICS
The University of Alabama at Birmingham

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

Patient Information Request Form

About Your Child

Child's Name: First | Last | MI

Date of Birth:

Gender: ☐ Male ☐ Female ☐ Other

Language: Which of the following best describes the way your child speaks most of the time?

- ☐ No Words
- ☐ Single words only (e.g., "juice," "bye bye," "more")
- ☐ Phrases (e.g., "more juice please," "go swing outside")
- ☐ Sentences (e.g., "I'm hungry mom," "I want to go swing outside")
- ☐ Complex Sentences (e.g., "I had fun at school today, because we got to watch a movie")

Motor: Which of the following best describes how your child gets around?

- ☐ Crawling/Not yet walking
- ☐ Walking, but falls often
- ☐ Walking, but not yet running
- ☐ Walking and running well

About your family

Caregivers:

Name: **Relationship to patient:**

Name: **Relationship to patient:**

Phone Number: | Alt. Phone Number: | Email Address

Address: Street | City | State | Zip

Preferred Language: **Will you need an interpreter?** ☐ Yes ☐ No

Legal Guardian (if different from above)

Name: **Relationship to patient:**

Reason for Coming to Clinic

☐ My child does not have a diagnosis and needs to be evaluated

Please list any specific diagnoses that you have questions about.

☐ My child already has a diagnosis or diagnoses:

Diagnosis

☐ I would like a second opinion

☐ I have questions about medications or medical problems (e.g., sleep, eating, tics, seizures, etc.)

☐ Other:

☐ My child's doctor has concerns about my child, but I'm unsure.

Additional Information:

I have concerns about my child's:

Development

☐ Gross motor skills (running, jumping, balance)

☐ Fine motor skills (writing, using forks/spoons)

☐ Cognitive (thinking, intelligence, memory)

☐ Toileting (toilet training, bedwetting, accidents)

☐ Learning (school grades, attention, learning new skills)

Behavior/Mood

☐ Anxiety/Depression

☐ Hyperactivity/Inattention

☐ Aggressions or tantrums

☐ Obsessive or repetitive behaviors

☐ Intense interests

☐ Self-injury or dangerous behaviors

Communication

☐ Speech or language

☐ Hearing

☐ Social Skills (playing with toys, making friends)

Other

☐ Eating/nutrition

☐ Vision

☐ Sleep problems

About your child's medical history

Primary Care Doctor:

Birth History

Hospital

☐ Full-term ☐ Early

Number of weeks

Complications during pregnancy, delivery, or hospital stay.

Current Medical Information

Current Medications

Current Medical Problems

Allergies

Hearing

- ☐ Hearing was tested, no concerns
- ☐ Hearing was tested, problems reported
- ☐ Hearing has not been tested
- ☐ My child has a known hearing impairment (e.g., hearing loss)
- ☐ Other (specify below)

Vision

- ☐ Vision was tested, no concerns
- ☐ Prescribed glasses, wears them regularly
- ☐ Prescribed glasses, does not wear them
- ☐ Not tested, but no concerns
- ☐ Other (specify below)

Hearing or Vision Concerns

Insurance Information *If you prefer you may attach copies of the front and back of your insurance card*

Insurance Company Name:

Policy #:

Group #:

Primary Insured:

Name | Date of Birth | Relationship to Patient

Address:

Street | City | State | Zip

BIRTH, TREATMENT, AND SCHOOL HISTORY SERVICES

Please fill in the following information for your child. It is very important that you give the complete address of each Agency/Provider you list.

If your child's records might be listed under another name, please list that name below:

Type of Service Provider	Agency/Provider Name	Agency/Provider Address	Date(s) Seen
Place of Birth			
Pediatrician			
Current School			
Orthopedist			
Neurologist			
Eye Specialist			
Hearing Specialist			
Ear-Nose-Throat (ENT)			
Psychiatrist			
Psychologist/Counselor			
Nutritionist/Dietician			
Occupational Therapist			
Physical Therapist			
Speech/Language Therapist			
Department of Human Resources (DHR)			
Geneticist			