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

_____

_____

_____

_____

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 (heat 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: _____