

# RICARDO BERNAL, MD

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## DEVELOPMENTAL FORM

**PATIENT NAME:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Form completed by:** \_\_\_\_\_

### PREGNANCY AND BIRTH

Was this a planned pregnancy?  YES  NO

Was mother in good health?  YES  NO

If not, check below:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Morning Sickness    | <input type="checkbox"/> Swelling                    | <input type="checkbox"/> Kidney Problems     |
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Heart Problems              | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vaginal Bleeding (spotting) | <input type="checkbox"/> Measles: kind _____ |
| <input type="checkbox"/> Thyroid Disorder    | <input type="checkbox"/> Eating Problems             | <input type="checkbox"/> Weight Problems     |
| <input type="checkbox"/> Infectious Disease  | <input type="checkbox"/> RH or Other Blood Problems  | <input type="checkbox"/> Drug Dependency     |
| <input type="checkbox"/> Drug Reaction       | <input type="checkbox"/> X-Ray (include Dental)      | <input type="checkbox"/> Falls or Injuries   |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Jittery Nerves              | <input type="checkbox"/> Other               |

Explain and give treatment received for any of the above:

\_\_\_\_\_  
\_\_\_\_\_

Was mother hospitalized or confined to bed during this pregnancy?  YES  NO

Explain: \_\_\_\_\_

\_\_\_\_\_

Was delivery normal?  YES  NO

If not, check below:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Early Delivery        | <input type="checkbox"/> Late Delivery         | <input type="checkbox"/> Labor Induced           |
| <input type="checkbox"/> Dry Birth             | <input type="checkbox"/> Caesarean Section     | <input type="checkbox"/> Baby's Position Changed |
| <input type="checkbox"/> Low Forceps Delivery  | <input type="checkbox"/> High Forceps Delivery | <input type="checkbox"/> Breech Delivery         |
| <input type="checkbox"/> Other (specify) _____ |  |  |

Length of Labor: \_\_\_\_\_ hours

## **BIRTH**

Weight \_\_\_\_\_ Length \_\_\_\_\_ Head Measurement \_\_\_\_\_

Chest Measurement \_\_\_\_\_  Single Birth  Twins  Identical  Fraternal

Other multiple birth: (specify) \_\_\_\_\_

Was the baby's condition at birth normal?  YES  NO

If not, check below:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Weak Birth Cry     | <input type="checkbox"/> Listless, Inactive     | <input type="checkbox"/> Slow Heartbeat       |
| <input type="checkbox"/> Rapid Heartbeat    | <input type="checkbox"/> Breathing Problems     | <input type="checkbox"/> Lack of Oxygen       |
| <input type="checkbox"/> Blue Baby          | <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> In Incubator         |
| <input type="checkbox"/> Jaundice           | <input type="checkbox"/> Birth Defect           | <input type="checkbox"/> Feces in Birth Fluid |
| <input type="checkbox"/> RH Incompatibility | <input type="checkbox"/> Other: (specify) _____ |   |

Comments on any of the above: \_\_\_\_\_  
\_\_\_\_\_

APGAR Score, if known: \_\_\_\_\_

Number of days in the Hospital: Mother: \_\_\_\_\_ days Baby: \_\_\_\_\_ days

Following birth did either parent experience emotional stress?  YES  NO

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

## **EARLY INFANCY**

Was the baby's condition satisfactory during the first few weeks?  YES  NO

If NO, please check below:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Weak Suck             | <input type="checkbox"/> Colic               | <input type="checkbox"/> Breathing Problem |
| <input type="checkbox"/> Feeding Problems      | <input type="checkbox"/> Sleeping Problem    | <input type="checkbox"/> Weak Cry          |
| <input type="checkbox"/> Other Crying Problems | <input type="checkbox"/> Fussy Baby          | <input type="checkbox"/> Bowel Problems    |
| <input type="checkbox"/> Failure to Thrive     | <input type="checkbox"/> Projectile Vomiting | <input type="checkbox"/> Hospitalizations  |

Describe Problems and treatment: \_\_\_\_\_  
\_\_\_\_\_

Was baby breast fed?  YES  NO

Explain any problems: \_\_\_\_\_  
\_\_\_\_\_

Did baby make normal growth and weight gain?  YES  NO

**DEVELOPMENTAL**

Was the baby responsive (cuddly, smiled, cooed, gurgled)?  YES  NO

Indicate in weeks, months or years when your child first did the following:

Smile:	_____
Recognized Mother	_____
Respond to: Affection	_____
Facial Changes	_____
Voices	_____
Objects, toys	_____
Heat and Cold	_____
Pain	_____
Raised head up	_____
Rolled over from stomach to back	_____
Grasped objects	_____
Sat with Support	_____
Sat up alone	_____
Walked first steps	_____
Babbled	_____
Used jargon (sounds like speech)	_____
Said first words	_____
Used 2-3-word phrases	_____
Used Sentences	_____
Used meaningful gestures to indicate wants	_____
First began to talk	_____
Comments:	_____

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Did your child fail to develop normal speech?  YES  NO

When did your child understand spoken language? \_\_\_\_\_ months

Has your child had speech problems?  YES  NO

If YES, please check below:

- Speech was delayed (slow)
- Speech was not understandable
- Stopped talking after the speech started
- Repeats over and over the same sounds, words, phrases, or sentences (echolalia)
- Avoids talking to other people
- Stutters or stammers

Has your child had hearing problems?  YES  NO

If YES, please explain: \_\_\_\_\_

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Has your child had vision problems?  YES  NO  
If YES, please explain: \_\_\_\_\_

At what age did your child accomplish the following:  
Bladder Training \_\_\_\_\_  
Bowel Training \_\_\_\_\_  
Feeding Self \_\_\_\_\_  
Dressing Self \_\_\_\_\_

Check problems below in bowel or bladder control:  
 Has physical defect  Has constipation problems  
 Soils Pants  Has Diarrhea  
 Wets Pants  Has peculiar toilet habits  
 Soils Bed  Other: Specify \_\_\_\_\_

Comments: \_\_\_\_\_

Check problems in any of the following areas:  
 Balance  Holding pencil or crayon  
 Walking  Holding Spoon  
 Running  Cutting with Scissors  
Is your Child:  
 Right-Handed  Left-Handed  Both  I do not know

Does your child have excessive fears?  YES  NO  
Please explain: \_\_\_\_\_

Have there been incidents which seemed to be traumatic or terrifying to your child?  
 YES  NO  
Please explain (include duration, age at time of incident, and child's reaction to incident):  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any of the following habits or mannerisms?  YES  NO  
**AGE**  
 Peculiar hand movements \_\_\_\_\_  
 Peculiar sounds \_\_\_\_\_  
 Flushing toilet repeatedly \_\_\_\_\_  
 Compulsive water plays \_\_\_\_\_  
 Tics, Facial twitches, Involuntary grunts or sound \_\_\_\_\_  
 Other involuntary movements \_\_\_\_\_  
 Periods of withdrawal \_\_\_\_\_

**AGE**

- Obsession or extreme preoccupation with one activity \_\_\_\_\_
- Rocking \_\_\_\_\_
- Unusual rituals \_\_\_\_\_
- Head banging \_\_\_\_\_
- Obsessive cleanliness \_\_\_\_\_
- Bad dreams or nightmares \_\_\_\_\_

**RELATIONSHIPS**

Is your child affectionate?  YES  NO  
If NO, please explain: \_\_\_\_\_

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Is your child generally cooperative?  YES  NO  
If NO, please explain: \_\_\_\_\_

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Does your child seem insecure?  YES  NO  
If YES, please check below:

- Excessively jealous of brothers and sisters
- Fear of separating from parents
- Constantly seeking attention
- Too shy
- Consistently seeks reassurance
- Fears of new experience
- Cannot hold his/her own with peers
- Afraid of adults

Does your child make friends?  YES  NO  
If NO, please explain: \_\_\_\_\_

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Does your child have conflicts with other children or adults?  YES  NO  
If YES, please check below:

- Poor at games
- Teased by others
- Taken advantage of
- Excluded by other children
- Refuses to play with other children
- Blames other children
- Impudent or sassy to adults
- Disobedient
- Attacks other children
- Torments other children
- Has tantrums/loses temper
- Too Bossy
- Insist on having own way
- Ignores other children
- Disliked in neighborhood
- Difficult to manage

Additional explanations or comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SCHOOL**

List all schools attended, specify grade placement for each:


Has your child had problems at school?  YES  NO

If YES, please check below:

- |   |   |
|---|---|
| <input type="checkbox"/> Daydreaming              | <input type="checkbox"/> Learning Problems      |
| <input type="checkbox"/> Behavior problems        | <input type="checkbox"/> Poor Marks             |
| <input type="checkbox"/> Frequent absences        | <input type="checkbox"/> Disobedience           |
| <input type="checkbox"/> Fear of school           | <input type="checkbox"/> Conflicts with teacher |
| <input type="checkbox"/> Refusal to attend school | <input type="checkbox"/> Problems with peers    |

Describe problems and give grades they occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been retained or repeated a grade?  YES  NO

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION**

Does your child now take medicine of any kind?  YES  NO

What kind? \_\_\_\_\_ How much? \_\_\_\_\_

What for? \_\_\_\_\_ How Long? \_\_\_\_\_

Is he/she allergic to any medicine?

YES

NO

List and explain: \_\_\_\_\_

Please check mark any of the following things your child has had:

- |   | <b>AGE</b> |   | <b>AGE</b> |
|---|------------|---|------------|
| <input type="checkbox"/> Chicken Pox                  | _____      | <input type="checkbox"/> Bladder Problems                 | _____      |
| <input type="checkbox"/> Red Measles                  | _____      | <input type="checkbox"/> Vaginal Discharge                | _____      |
| <input type="checkbox"/> Mumps                        | _____      | <input type="checkbox"/> Vaginal Bleeding                 | _____      |
| <input type="checkbox"/> Whooping Cough               | _____      | <input type="checkbox"/> Encephalitis                     | _____      |
| <input type="checkbox"/> Scarlet Fever                | _____      | <input type="checkbox"/> Polio                            | _____      |
| <input type="checkbox"/> Frequent Fevers              | _____      | <input type="checkbox"/> Diphtheria                       | _____      |
| <input type="checkbox"/> Frequent or severe headaches | _____      | <input type="checkbox"/> Heart Murmur                     | _____      |
| <input type="checkbox"/> Dizzy Spells                 | _____      | <input type="checkbox"/> Asthma                           | _____      |
| <input type="checkbox"/> Nosebleeds                   | _____      | <input type="checkbox"/> Eczema                           | _____      |
| <input type="checkbox"/> Breathing Problems           | _____      | <input type="checkbox"/> Hay Fever                        | _____      |
| <input type="checkbox"/> Chest pain                   | _____      | <input type="checkbox"/> Hives                            | _____      |
| <input type="checkbox"/> Vomiting                     | _____      | <input type="checkbox"/> Allergies                        | _____      |
| <input type="checkbox"/> Stomach upsets or pain       | _____      | <input type="checkbox"/> Skin Problems                    | _____      |
| <input type="checkbox"/> Frequent Diarrhea            | _____      | <input type="checkbox"/> Worms                            | _____      |
| <input type="checkbox"/> Constipation                 | _____      | <input type="checkbox"/> Other chronic medical conditions | _____      |
| <input type="checkbox"/> Blood in stool               | _____      |   |            |

Visual Problems: (Please specify)

\_\_\_\_\_

Hearing Problems: (Please specify)

\_\_\_\_\_

Other: (Please specify)

\_\_\_\_\_

Has your child had any serious illnesses?

YES

NO

Explain each, give date or age, duration and medications given:

\_\_\_\_\_

\_\_\_\_\_

Has your child had any significant injuries or accidents?

YES

NO

Please explain each and give dates:

\_\_\_\_\_

\_\_\_\_\_

Was the child unconscious?  YES  NO  
Has your child been hospitalized?  YES  NO  
Please explain and give dates:

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Has your child had surgery?  YES  NO  
Please explain and give dates:

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Does your child have allergies?  YES  NO  
Please explain:

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Has your child ever had fainting, fits, seizures, convulsions or momentary staring or rolling back of the eyes?  YES  NO  
Please explain:

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Please explain at what age? \_\_\_\_\_ Does the condition still exist? \_\_\_\_\_

Has your child ever had blood transfusions?  YES  NO  
If yes, when: \_\_\_\_\_  
Why? \_\_\_\_\_

Check any of the following conditions in your family:

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Liver Disease                |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Mental Retardation           |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Muscle Disease               |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Physical Disability          |
| <input type="checkbox"/> Brain Damage   | <input type="checkbox"/> Migraine                     |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Psychosis (mental illness)   |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Thyroid Disorder             |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Hearing Defect | <input type="checkbox"/> Convulsions                  |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Visual Defect                |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Abnormalities: Specify _____ |

### **HABITS**

- Sleep Problems
- Bed-wetting
- Soiling
- Eating problems
- Nail-biting
- Thumb-sucking
- Hair-pulling
- Tics, twitching, blinking
- Masturbation
- Physical complaints
- Head Banging
- Rituals
- Obsessive cleanliness
- Rocking
- Headaches
- Stuttering
- Drug Use

### **SCHOOL**

- Reading problems
- Poor concentration
- Learning problems
- Problems studying
- Underachievement

### **DEVELOPMENTAL**

- Health Problems
- Poor coordination
- Delayed Development
- Speech problems
- Hearing problems
- Vision problems
- Physical handicap

### **RELATIONSHIPS**

- Clinging
- Demanding
- Dislikes mother
- Dislikes father
- Jealous of brother/sister
- Shy
- Bossy
- Ignore others
- Does not get along with teach

### **EMOTIONS**

- Sad or depressed
- Angry
- Fearful
- Withdrawn
- Over-anxious
- Unhappy
- Sullen
- Cries easily
- Sensitive
- Daydreams
- Imagines things
- Bad dreams or nightmare
- Hallucinations
- Loses temper
- Preoccupied
- Humorless

**BEHAVIOR**

- |  |   |
|--|---|
| <input type="checkbox"/> Poor sense of right and wrong | <input type="checkbox"/> Lacks initiative     |
| <input type="checkbox"/> Does not respect authority    | <input type="checkbox"/> Accident-prone       |
| <input type="checkbox"/> Fights                        | <input type="checkbox"/> Overactive           |
| <input type="checkbox"/> Cheats                        | <input type="checkbox"/> Lazy                 |
| <input type="checkbox"/> Steals                        | <input type="checkbox"/> Blame others         |
| <input type="checkbox"/> Lies                          | <input type="checkbox"/> Wanders off          |
| <input type="checkbox"/> Tantrums                      | <input type="checkbox"/> Unreliable           |
| <input type="checkbox"/> Destructive                   | <input type="checkbox"/> Irresponsible        |
| <input type="checkbox"/> Skips school                  | <input type="checkbox"/> Easily frustrated    |
| <input type="checkbox"/> Mistreats other children      | <input type="checkbox"/> Unpredictable        |
| <input type="checkbox"/> Set fires                     | <input type="checkbox"/> Cruel to animals     |
| <input type="checkbox"/> Runs away                     | <input type="checkbox"/> Perseveration        |
| <input type="checkbox"/> Rages                         | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Quarreling                    | <input type="checkbox"/> Compulsive           |
| <input type="checkbox"/> Rebellious                    | <input type="checkbox"/> Immature             |
| <input type="checkbox"/> Classroom behavior problem    | <input type="checkbox"/> Manipulates          |

**COMMENTS:**

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\_\_\_\_\_  
**PATIENT / GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**