



**Dell Children's Neuroscience Center - Developmental Program**  
**6811 Austin Center Blvd Suite #400, Austin 78731**  
**512-628-1852 for appointment**

**Purpose**

The Pediatric Developmental Program, part of the Dell Children's Neuroscience Center - provides diagnostic evaluations for autism, developmental delay, ADHD and follow-up for infants and children who are at risk for developmental delay due to premature birth or other perinatal events. Standardized diagnostic tests are used to assess developmental milestones and children are managed using a medical model to meet their developmental needs. We DO NOT perform cognitive testing for children over 5 years old. Diagnostic reports with treatment recommendations are sent to the primary care provider and appropriate agencies for treatment.

**Location/Scheduling/Contact:**

We are located at the new Seton Family of Doctors building off the Far West exit and Mopac next to Austin Regional Clinic. Appointments are scheduled through the Child Neurology Clinic. For appointments, call 512-628-1852. Parents can obtain a referral through their primary care provider. For general questions regarding the program, you can call 512-609-9564 and speak with Cris Gonzalez, LCSW, program social worker.

**Team Members**

Developmental Behavioral Pediatrician  
Pediatric Nurse Practitioner  
Physical Therapist  
Occupational Therapist  
Speech Therapist  
Social Worker

**The Evaluation:**

Evaluations usually involve 2-3 visits. We discourage same day sibling appointments. Due to the length of the evaluations, most children do not have the attention span or frustration tolerance to endure back to back visits. The first visit will be an initial consult by the developmental-behavioral pediatrician or nurse practitioner who will review the child's developmental and medical history and perform a comprehensive physical exam and developmental screening. Some children will be referred for further comprehensive developmental testing or evaluations by a speech, occupational and/or physical therapist. Evaluations by the therapists may occur at the Children's Therapy Gym at Dell Children's Medical Center. Results of testing as well as treatment recommendations are shared with parents on a follow up visit with the developmental pediatrician. The child does not have to come to the feedback session.

**What You Need To Bring:**

Please complete the first five pages of the Developmental-Behavioral Intake Forms and bring a picture of your child in his/her "normal" setting (please be sure your child is the *only* one in the picture). The appointments can take 1-2 hours so bring your child's favorite toys, snacks or any items that may help him/her be more comfortable for the visit. The intake form, outside therapy, educational or medical records should be faxed to 512-628-1851 BEFORE the day of the appointment.

**Insurance:**

We encourage you to contact your insurance company to verify your benefits. Please note: therapy evaluations at Dell Children's Medical Center may be subject to your deductible. If you have any questions or concerns regarding evaluations at the Children's Therapy Gym please contact the Specialty Care Center at 512.324.0137.

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**Our mission** inspires us to care for and improve the health of those we serve with a special concern for the sick and the poor.  
We are called to Service of the Poor, Reverence, Integrity, Wisdom, Creativity and Dedication.

**CHILD'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**PERSON COMPLETING FORM:** \_\_\_\_\_ **DATE FORM COMPLETED:** \_\_\_\_\_

**CHILD'S PRIMARY CARE PROVIDER:** \_\_\_\_\_

**LIST CONCERNS ABOUT YOUR CHILD'S HEALTH, DEVELOPMENT and BEHAVIOR:** please use extra space on the last page if needed

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**Please share with us what you hope to get from your visit:** please use extra space on the last page if needed

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**PREGNANCY & BIRTH** please use extra space on the last page if needed

Is the child yours by:  birth  adoption  stepchild  other: \_\_\_\_\_

Birthplace \_\_\_\_\_ Please list any medical problems during your pregnancy  none  other: \_\_\_\_\_

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Delivery by  vaginal birth  Caesarian If Caesarian, why? \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR score (if known) 1 min \_\_\_\_\_ 5 min. \_\_\_\_\_

Please indicate any medical problems during the baby's newborn period  none

If premature, how early? \_\_\_\_\_ Other problems: \_\_\_\_\_

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**NUTRITION & FEEDING** please use extra space on the last page if needed

How was/is your infant fed?  bottle fed  breastfed how long? \_\_\_\_\_

Milk intake now: Type  cow milk ( skim  1% fat  2% fat  whole milk)  soy milk  rice milk

Average ounces per day (Note: 8 ounces are in 1 cup) \_\_\_\_\_  uses a bottle  uses a cup

Juice intake:  none Average ounces per day \_\_\_\_\_

On a special diet?  No  Yes If yes, please explain: \_\_\_\_\_

Has your child had any unusual feeding/dietary problems?  No  Yes If yes, please explain: \_\_\_\_\_

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**SLEEP** please use extra space on the last page if needed

Bedtime \_\_\_\_\_ Hours per night \_\_\_\_\_ Naps (number & length) \_\_\_\_\_

Any sleep problems? \_\_\_\_\_

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**DEVELOPMENT** please use extra space on the last page if needed

At what age did your child: sit alone \_\_\_\_\_ walk alone \_\_\_\_\_ say words \_\_\_\_\_ toilet train \_\_\_\_\_

If you are concerned about your child's development, at what age did you begin to worry? \_\_\_\_\_

**IMMUNIZATIONS/INFECTIOUS DISEASES:** Please bring your child's shot record to your appointment.

Has your child had:  chickenpox  measles  mumps  rubella  meningitis  tuberculosis (TB)

**ALLERGIES TO MEDICINES:**  none  other \_\_\_\_\_

**MEDICINES/VITAMINS:**  none  other \_\_\_\_\_

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**SOCIAL HISTORY**

Who lives at home?

Name	Age	Relationship	Highest Education level

Parents are:  married  not married  separated—since: \_\_\_\_\_  divorced—since: \_\_\_\_\_

Parents' employment: Mother \_\_\_\_\_ Father \_\_\_\_\_

Is violence at home a concern?  No  Yes Are there guns in the home?  No  Yes

Child care situation  parents  others (specify who and hours per day) \_\_\_\_\_

If your child is old enough to do extracurricular activities or sports, please list them: \_\_\_\_\_

**BEHAVIORAL and SCHOOL HISTORY**

Was/Is your child :	During the first 12 months?		Now?	
	Yes	No	Yes	No
Colicky			N/A	
Difficult to feed				
Difficult to get to sleep				
Difficult to put on a schedule				
Alert				
Easy to comfort				
Affectionate				
Difficult to keep busy				
Cheerful				
Overactive, in constant motion				
Very stubborn, challenging				
Irritable or grouchy				
Sociable				

Did/does your child attend occupational, physical or speech therapy?  No  Yes  OT  PT  ST

For each grade your child has been in, beginning with preschool, please tell us the school attended and whether she or he had any learning or behavioral problems that year.

<u>School</u>	<u>Age or grade</u>	<u>Special classes</u>	<u>Learning or behavioral problems</u>

Any concerns about current school performance?  N/A  No  Yes \_\_\_\_\_

Any concerns about relationships with: Teachers  N/A  No  Yes \_\_\_\_\_

Students  N/A  No  Yes \_\_\_\_\_

If over 4 years old, does your child have a best friend?  No  Yes \_\_\_\_\_

**BEHAVIORAL HISTORY continued**

What prompted you to seek an evaluation of your child's behavior *at this time*?

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How have you tried to manage your child's behavior, especially when it is a problem for you?

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When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

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If these methods do not work and the problem behavior continues, what are you likely to do then to cope with your child's misbehavior? \_\_\_\_\_

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Are you and your spouse (or partner) consistent in managing your child's behavior?  **No**  **Yes** If no, please explain: \_\_\_\_\_

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Are your beliefs about discipline consistent with your spouse or partner's?  **No**  **Yes** If no, please explain: \_\_\_\_\_

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What qualities does your child have that you particularly enjoy? \_\_\_\_\_

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What do you consider to be your child's strongest or best points? \_\_\_\_\_

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**Has your child ever been evaluated previously for developmental, behavioral, or learning problems?**  No  Yes

If so, when, who provided the evaluation, what type of evaluation did the child have, and what were you told about your child regarding the results of any evaluations?

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**Has your child ever been seen or treated by a neurologist?**  No  Yes

If so, when, who was the doctor, what tests (EEG's, brain scans) were done, and what medications if any were prescribed?

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**Has your child ever received any psychiatric or psychological treatment?**  No  Yes

If so, what type of treatment did she/he receive and how long did the treatment last? Who provided this treatment to your child?

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**Has your child every received *medication* for behavior or emotional problems?**  No  Yes

If so, who was the doctor, what type of medication did your child take, at what dose, and for how long?

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