Dear Caregiver,

We are happy to confirm that we have received a referral from your child's primary care provider for services at the **Siskin Center for Developmental Pediatrics**. Thank you for choosing us to be a partner in your child's care. Our team is committed to providing high-quality care in a family-centered environment to ensure you and your child are comfortable and enjoy your visit(s). Enclosed you will find our new Patient Packet and instructions to complete the next steps in the registration process.

Please complete the packet, so that we can prepare for your child's evaluation. A pre-stamped return envelope has been provided for your convenience. The packet must be completed before an appointment can be scheduled. If you would like assistance in completing the forms, we will be happy to help you.

Please call Lisa Spurlock (423) 648-1740 or Wendy Bennett (423) 648-1704.

Once we receive your packet, the next step will be scheduling an appointment. Please feel free to contact us with any additional questions you may have.

We look forward to serving your family!

APOINTMENT REMINDERS

- First appointment may take up to 2 hours. This gives our team the opportunity to understand your concerns, your child's developmental history, and evaluate your child. Please consider making alternative arrangements for siblings if possible.
- Please bring hearing and vision screening evaluations, educational/school testing, and other relevant testing results.
- Please bring a copy of IEP, IFSP or other therapy notes (OT, PT, and Speech) and a list of all medications (prescriptions, over-the-counter, and supplements).

IMPORTANT APPOINTMENT INFO

1. You must check-in with the main lobby receptionist in order to be seen.

2. If you are more than 15 Minutes late, we might have to reschedule.

3. If you have not heard from anyone within 15 minutes of checking in, please speak to the receptionist.

CHATTANOOGA
1101 CARTER STREET, CHATTANOOGA 37402
PHONE: 423.490.7710 FAX: 423.490.7750
HOURS: MONDAY – FRIDAY 8AM-5PM

siskin children's institute

NASHVILLE
2201 MURPHY AVE. SUITE 306, NASHVILLE 37203
PHONE: 615.730.8095 FAX: 615.730.9135
HOURS: MONDAY-THURSDAY 8AM-6PM

Center for Developmental Pediatrics | Patient Intake

siskin children's institute

1. IDENTIFYING INFORMATION

DATE COMPLETED _____

Child's Name: _____ Birth Date: _____ Sex: _____

Name of person completing this form: _____

You are: ☐ Biological Parent ☐ Adoptive Parent ☐ Foster Parent Other: _____

Do you have legal guardianship? Yes: ☐ No: ☐ If No, who does? _____

Primary language at home: English: ☐ Spanish: ☐ Other: ☐ _____

2. CAREGIVER INFORMATION

Email: Primary Phone #:

Caregiver 1	**Caregiver 2** *(if applicable)*
Name:	Name:
Birth Date:	Birth Date:
Employer & Occupation:	Employer & Occupation:
Highest School Grade Completed:	Highest School Grade Completed:
Marital Status:	Marital Status:

3. PARENTAL CONCERNS

Describe what concerns you have about your child's development, learning, and/ or behavior? (Please indicate the age these concerns were first noticed) _____

_____

Has your child had previous evaluations for these concerns? No: ☐ Yes: ☐ If so, where: _____

What are your goals for this visit? _____

_____

Describe your child's

Strengths: _____

Challenges: _____

4. THERAPY SERVICES

Has your child ever been recommended for or received therapy outside of school? No: ☐ Yes: ☐

If Yes, select from the following:

Therapy	**Current**	**Location**	**Dates**
Speech and Language Therapy (ST)	☐ No ☐Yes		
Occupational Therapy (OT)	☐ No ☐Yes		
Physical Therapy (PT)	☐ No ☐Yes		
Behavior Therapy/ Counseling	☐ No ☐Yes		
Early Intervention (TEIS, BCW)	☐ No ☐Yes		
Other (e.g. ABA)	☐ No ☐Yes		

5. DEVELOPMENTAL MILESTONES

To the best of your abilities, please write at what age did your child meet these milestones? Indicate age in months. (*If milestone has not been met, mark N/A.)*

Motor	Language
Rolled Over:	Babble:
Sit without support:	Say Mama/Dada:
Crawl:	Say another word:
Stood without support:	Point with index finger:
Walk Alone:	Wave:
Run:	Follow a command:
	Points to body parts:
	Use 2-word phrases:
	Use 3-word phrases:

6. CURRENT DEVELOPMENT

A.) Motor Skills

1. Do you have any concerns about your child's **gross** motor skills? (i.e. running, climbing, jumping) ? No: ☐ Yes: ☐
2. Do you have any concerns about your child's **fine** motor skills? (i.e. using their hands, holding utensils, etc.) No: ☐ Yes: ☐
3. Any history of regression in motor skills? (Lost skills, stopped doing things he/she was doing?) No: ☐ Yes: ☐

SKILL	NO	YES
Does your child have problems with balance/coordination?	☐	☐
Can your child use a spoon to eat?	☐	☐
Can your child use a fork to eat?	☐	☐
Can your child drink from an open cup?	☐	☐
Can your child scribble with a pen/crayon?	☐	☐
Is your child toilet/potty trained? At what age? _____	☐	☐
Can your child undress self?	☐	☐
Can your child dress self?	☐	☐

B.) Speech & Language

Expressive Language

1. Do you have any concerns about your child's communication skills? ☐ No ☐ Yes, explain:

2. Currently, is your child? Non-verbal ☐ Babbling ☐ **Using**: Single words ☐ Phrases ☐ Full sentences ☐
3. How many words is your child saying spontaneously? (not repeating after others) _____
4. Any history of language regression? (was saying words and then stopped) No: ☐ Yes: ☐
5. How does your child ask for help? (please check all that apply)

BEHAVIOR	PLEASE CHECK
Sign Language	☐
Crying	☐
Grunting	☐
Non-specific gesturing	☐
Pointing with index finger	☐
Using your hand to obtain desired objects	☐
Giving objects to others	☐
Using words/language	☐
Does not ask for help	☐

Receptive Language

1. Can your child follow directions? No ☐ Only a few familiar/routine ☐ One step ☐ Multiple Steps ☐

Repetitive Language

6. Does your child use language in a repetitive way? _____

7. Does your child repeat words just spoken by others? (i.e.: repeating a question or the last word of the question instead of answering it) No: ☐ Yes: ☐ If yes, how often? _____

8. Does your child repeat phrases/words from movies or TV shows? (not songs) If yes, how often and in what context (please explain)

No: ☐ Yes: ☐ _____

C.) Social Development

When answering these questions, please note that **YES** means that your child does these behaviors **MOST** of the time, and not only occasionally/rarely.

Does your child exhibit any of the following behaviors?

SKILL	NO	YES
Looks at you when you call his/her name	☐	☐
Typically looks at others when he/she is talking/saying words	☐	☐
Makes eye contact with others when he/she is talked to?	☐	☐
Smiles back in response to other's smile?	☐	☐
Shares enjoyment with others? (Looks for others to interact?)	☐	☐
Shows objects to others and make eye contact?	☐	☐
Points at objects with index finger to draw your attention (not to request)	☐	☐
Points at objects with index finger to request?	☐	☐
Gives things to others to share? (not to request)	☐	☐
Gives things to others to request?	☐	☐
Shows interest in other children?	☐	☐
Appears withdrawn/in their own world?	☐	☐
Plays interactively with others? (such as back-and-forth play)	☐	☐
At home, does your child prefer playing alone?	☐	☐
Looks for others to play with him/her (not just for help)	☐	☐
Uses gestures? (waves bye-bye, nods, shakes head, etc.)	☐	☐
Uses others' people's hands and move them towards objects?	☐	☐

D.) Play Skills

1. Describe your child's play, favorite toys, etc.: _____

2. Does your child engage in pretend play? (Feeding pretend food to baby dolls, stuffed animals, play pretend kitchen, play doctor, etc.) If so, how often (rarely, occasionally, often) _____

3. Does your child play with the toys the way they are intended to be used? (i.e.: he/she will roll cars, make train noises, use a bottle to feed a baby doll, etc.) _____

4. Are there certain objects that your child prefers to play with instead of toys? (i.e. strings, clothing hangers, cords, straws, etc.) _____

E.) Repetitive Behaviors

Does your child exhibit any of the following behaviors?

BEHAVIOR	NO	YES
Lines up objects	☐	☐
Spins objects	☐	☐
Flaps hands when upset or excited	☐	☐
Walks on tiptoes	☐	☐
Gets upset with changes in routines	☐	☐
Has difficulty with transitions	☐	☐
Is very rigid with how things need to be done/routines	☐	☐
Gets fixated on specific topics, toys, objects, TV shows	☐	☐

F.) Sensory

Does your child exhibit any of the following behaviors?

BEHAVIOR	NO	YES
Brings toys close to his/her eyes? Or inspects things from different angles	☐	☐
Seeks to touch or rub certain textures	☐	☐
Dislikes certain texture with food or touch	☐	☐
Has issues with loud noises?	☐	☐
Has problems with clothing, socks	☐	☐
Has a fascination with observing movements of things? (i.e. fans, wheels)	☐	☐
Smells objects/food	☐	☐

Do you think your child has autism/is autistic? No: ☐ Yes: ☐ I don't know ☐

7. BEHAVIOR

1. Do you have any concerns about your child's behaviors? No: ☐ Yes: ☐
2. Does your child exhibit any of these behaviors? (please check all that apply)
   - Self-injury ☐
   - Aggression towards others ☐
   - Destruction of property ☐
   - Elopement ☐
   - Severe disruptive behavior ☐
3. Are you concerned for your child's or others' safety? No: ☐ Yes: ☐
4. Does your child's behavior significantly interferes with home or community activities? No: ☐ Yes: ☐
5. If temper tantrums are occurring, where are they happening? (i.e. school, home, daycare, etc.)

8. FEEDING/ NUTRITION

1. Does your child eat a limited variety of foods compared to peers? No: ☐ Yes: ☐
2. Is your child very rigid with what he/she eats and only eats certain foods? No: ☐ Yes: ☐
3. Does your child cough and/or choke while eating and/or drinking No: ☐ Yes: ☐

9. SLEEP

Does your child currently have sleep problems? No: ☐ Yes: ☐ Explain:
Does your child: ☐Snore ☐Take a long time to fall asleep ☐ Has pauses while breathing during sleep

1. What time is your child: In bed: _____ Asleep: _____ AM wake up: _____
2. Does your child wake up in the middle of the night? No: ☐ Yes: ☐
   - How many times? _____
   - How long does he/she stay awake? _____
3. Does your child take any medication for sleep? No: ☐ Yes: ☐ If yes, which one and dose: _____

10. SCHOOL INFORMATION

1. Current school /preschool/daycare: _____ Grade: _____
2. Are you satisfied with your child's performance at school? No: ☐ Yes: ☐ If No, why? _____
3. Does your child have an IEP (Individualized Education Plan)? No: ☐ Yes: ☐ or a 504 plan? No: ☐ Yes: ☐
4. Is your child receiving additional services through the school? No: ☐ Yes: ☐ If Yes, select from the following:

☐Self- Contained Special Education
☐Resource Room
☐Classroom Modifications
☐Speech/Language Therapy (ST)
☐Occupational Therapy (OT)
☐Physical Therapy (PT)
☐Tutoring
☐Other

11. MEDICAL HISTORY

A.) Pregnancy History

Did the birth mother:	No:	Yes:	What month(s) of pregnancy?	Complications and or/ medications?
Receive prenatal care?	☐	☐		
Have illness or medical problems?	☐	☐		
Take prescription medications?	☐	☐		
Smoke? *(indicate how much)*	☐	☐		
Drink alcoholic beverages? *(indicate how much)*	☐	☐		
Use illicit drugs/ substances *(type and amount, if known)*	☐	☐		

B.) Birth History:

Length of pregnancy?	Birth weight?
Was labor induced & why?	Did the baby need medical assistance in starting to breathe? No: ☐ Yes: ☐
Age of mother at delivery?	Was the baby admitted to the NICU? No: ☐ Yes: ☐ If yes, for how long?
Labor/Delivery complications?	How long did the baby stay in the hospital after birth?
Birth was ☐Vaginal ☐C-Section ☐Breech ☐ Twins or more	

C.) Past Medical History:

List past medical problems, including other specialty providers caring for your child:

1. Medications

Is your child allergic to any medications? No: ☐ Yes: ☐ If Yes, to what? _____

List all medicines, vitamins, or supplements your child currently takes (including for behavior or sleep)

Name	Dosage	Dates Taken	Reason/Response

2. Hospitalizations/ Surgeries

Has your child ever been hospitalized (including psychiatric hospitalization), had surgery, and/or had a major injury? No: ☐ Yes: ☐

Reason	Date	Hospital

3. Immunizations are: ☐ Up to date ☐ Incomplete ☐ Unknown status

4. Date of last Vision Test and results? **Date of last Hearing Test and results?**

5. Previous Medical Testing

Test	Result	Date
☐Genetic Testing		
☐CT Scans		
☐MRI Scans		
☐Sleep Study		
☐Allergy Testing		
☐Swallowing Studies		
☐Other:		

D.) Social History

A. Please list all persons living in the child's home below:

Name:	Age:	Relationship to Child:	Health:

B. Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Other

C. If separated or divorced, is there shared custody? No: ☐ Yes: ☐

Arrangements: _____

D. Who else cares for the child? _____

E. If applicable, was the child adopted? No: ☐ Yes: ☐ If Yes, at what age? _____

Circumstances of adoption: _____

If applicable, has the child been in foster care? No: ☐ Yes: ☐

Circumstances: _____

Total number of foster placements: _____

F. **Has your child ever experienced the following:**

	Yes	No	Unsure
Alcohol or drug abuse by a family member?	☐	☐	☐
Seeing parents hitting/ hurting each other?	☐	☐	☐
Witnessing violence (robbery, shooting, etc.)?	☐	☐	☐
Physical abuse?	☐	☐	☐
Sexual abuse?	☐	☐	☐

E.) Family History

No known family health problems? ☐ Unknown, child was adopted: ☐ Unknown for another reason: ☐

Please indicate if any of the child's relatives have had any of the following (i.e.: parent, sibling, grandparent, aunts/uncles, cousins, etc.)

CONDITION	FAMILY MEMBER	CONDITION	FAMILY MEMBER
☐ ADHD/ Attention Problems		☐ Tics/ Tourette Syndrome	
☐ Autism Spectrum Disorder		☐Thyroid Disorder	
☐ Behavior problems		☐ Sleep Disorder	
☐ Birth defects		☐Wolff-Parkinson-White syndrome	
☐ Congenital Heart Disease		☐Mental Illness:	
☐ Cerebral Palsy		☐Anxiety	
☐ Convulsions/ Seizures		☐Bipolar Disorder	
☐ Developmental Delay		☐Depression	
☐ Early or Sudden Death, if so cause:		☐Obsessive Compulsive Disorder (OCD)	
☐ Genetic Disorder		☐Schizophrenia	
☐ Hearing problems/ Vision problems		☐ Long QT Syndrome	
☐ Hypertrophic Cardiomyopathy		☐ Language/ Speech problems	
☐ Intellectual Disability		☐ Learning Problems	

Please note any other relatives with conditions not listed above in the space below:

12. REVIEW OF SYSTEMS: Has your child ever had any of the following?

System		Age	Details	System		Age	Details
Head	☐ Head Injuries			**Lungs**	☐ Repeated exposure to tobacco smoke		
	☐ Hydrocephalus				☐ Asthma		
Eyes	☐ Vision Problems				☐ Pneumonia		
	☐ Glasses			**Endo**	☐ Height/ Growth Problem		
Ears	☐ Hearing Problems				☐ Diabetes		
	☐ Recurrent Ear Infections			**GI**	☐ Soiling Day/ Night		
	☐ Hearing Aids				☐ Stomachache		
Nose	☐ Nosebleeds				☐ Weight Problem		
	☐ Recurrent Sinus Infections			**MS**	☐ Clumsiness		
Teeth	☐ Teeth Grinding				☐ Weakness		
	☐ Cavities				☐ Broken Bones		
Throat	☐ Recurrent Strep			**Neuro**	☐ Meningitis		
Allergy	☐ Seasonal				☐ Headache		
	☐ Food				☐ Dizziness		
Skin	☐ Dermatitis/ Eczema				☐ Seizures		
	☐ Birthmarks				☐ Tics		
Blood/ Lymp	☐ Lead Poisoning			**Psych**	☐ Depression		
	☐ Anemia				☐ Anxiety		
	☐ Bleeding				☐ Aggression		
Heart	☐ Heart Defects				☐ Disruptive Behavior		
					☐ Suicide/Homicidal Ideation		
					☐Hallucinations		

Please use the area below for any other information you feel will be helpful to use in evaluating your child

REVIEW & SIGN:

By providing my signature below, I affirm that I have truthfully answered the questions within this document to the best of my ability.
I understand that I have an affirmative responsibility to disclose any changes to this information to the provider as they may occur.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____ _____

siskin children's institute CENTER FOR DEVELOPMENTAL PEDIATRICS

A pediatric practice affiliated with The University of Tennessee College of Medicine Chattanooga, Department of Pediatrics and with Children's Hospital at Erlanger.

Dear Caregiver,

At the Center for Developmental Pediatrics at Siskin Children's Institute we care about the children and families we serve across our region. We are here to effectively work together in a collaborative manner to achieve the best developmental outcomes for your child. Due to the high volume of patients needing our specialized services, please be advised of the following **attendance policy**. Your signature is acknowledgement of the following practices.

- All patients must be brought to our center by the **parent or legal guardian**. We must have written legal documentation to support the legal guardian's right to seek care for the patient.
- In an effort to decrease the spread of illness, if your child is sick with fever, vomiting/diarrhea, respiratory problems, infection, or other communicable condition (e.g., lice, pink eye, ringworm, chicken pox, etc.) within 24 hours of the appointment we ask that you reschedule the visit.
- **Initial medical appointment**: Please arrive 30 minutes before your appointment to allow the check-in process to go smoothly and complete the appropriate paperwork.
- **Late arrival for appointment**: If you arrive 15 minutes after your scheduled appointment, we will do our best to accommodate you. However, it may be necessary to reschedule your appointment for another day.
- **Cancellations**: Please notify our center of cancellations at least 48 hours before the scheduled appointment time. This allows the office to schedule another patient in need of an appointment.
- If patient **misses 3 medical appointments** within 12 months, you may be asked to find another provider for services.

If you have questions, please feel free to ask a member of our staff by calling 423-490-7710

We appreciate your cooperation and we look forward to serving your family.

I understand the above statements:

_____ _____

Signature Date

_____ _____

Print Name Child's Name / DOB