Thank you for your interest in the services provided at Schmieding Developmental Center (SDC) a program of the University of Arkansas for Medical Sciences, College of Medicine, Department of Pediatrics.

SDC recently received a referral from your child’s primary care provider &/or medical specialist. In order to best meet the needs of your child, please complete and return the included Patient Information Packet to SDC at your earliest convenience. Incomplete Patient Information Packets will delay processing. Once the completed packet has been received, the triage team will review and request additional information as needed.

*If your child has been previously evaluated for developmental and/or behavioral concerns (i.e., speech therapy, psychoeducational/developmental or psychiatric evaluations, etc.) and you have copies of any of their reports, please mail/fax them to our clinic along with this form.

When all information has been obtained, a clinician will review and determine if a comprehensive evaluation is warranted. Once the need for an evaluation has been determined, an appointment can be scheduled. Unfortunately, due to the specialized services, we provide and the large number of referrals that SDC receives, families often have to wait several months for an appointment. If a comprehensive evaluation is not warranted, you and the referring physician will receive notification with recommendations indicating what services would best meet the needs of your child.

SDC accepts Arkansas Medicaid and most private insurances.

If you have any changes to your contact information before your appointment, please contact our office to update your record. Two days prior to your appointment, you will receive a phone call to confirm the appointment. If SDC is unable to obtain a verbal confirmation, your appointment will be cancelled.

Please mail your completed Patient Information Packet with the requested information to our clinic within 3 weeks of receiving it (if completed packet is not received within the time allotted, referral will be discharged and PCP will be notified):

Mailing Address
SDC: New Patient Packet
519 Latham Drive
Lowell, AR 72745

If you have questions or concerns, please contact SDC at 479-750-0125 press option 1 then option 2 to talk to a staff member or email us at sdc@uams.edu. We look forward to working with you and your child.

Sincerely,

Mary Ann Scott, Ph.D.
Pediatric Neuropsychologist
SDC Administrative Director
(ELECTRONIC SIGNATURE ATTACHED)
Please note, items marked by an “*” are used for statistical purposes only and will not affect your application.

PATIENT and GUARANTOR INFORMATION:
Child’s Name___________________________________________________ Birth Date_____________ Age__________ *Sex__________ *Race__________ Primary Language__________________ Social Security #____________________
Medicaid Policy #____________________ Insurance Co.____________________ Group #____________________ Policy #____________________ Subscriber____________________ Relationship to Patient____________________
Guarantor’s Name___________________________________________________ Relationship to Patient____________________
Social Security #____________________ Birth Date____________________ Employer____________________ Home Phone #____________________ Work Phone #____________________ Cell Phone #____________________ E-Mail____________________
Guarantor’s Address________________________________________________________________________________
P. O. Box       or        Street________________________________________________________________________________
City State Zip Code County
Legal Guardian’s Name___________________________________________________ Relationship____________________
Home Phone #____________________ Work Phone #____________________ Cell Phone #____________________ E-Mail____________________
Guardian’s Address________________________________________________________________________________
P. O. Box       or        Street________________________________________________________________________________
City State Zip Code County
EMERGENCY INFORMATION:
Nearest Relative___________________________________________________ Relationship____________________ Phone____________________
Primary Physician___________________________________________________ Phone____________________

**By providing your email address and signing below, you are agreeing that we may send medical related correspondence to you via email. You may withdraw your consent to email correspondence at any time by notifying a member of our office staff**

Please fill out this form as completely as possible. This information is necessary to determine your child’s accurate diagnosis and how best to serve your child needs.

Who referred you to this clinic?
Name___________________________________________________ Relationship____________________ Phone #____________________

PARENT’S or CAREGIVER’S CONCERNS:
What are your current concerns____________________________________________________
What have you been told by doctors, teachers, and/or others about your child’s problem? ________________________________
What do you expect or hope to have happen as a result of an evaluation at the Schmieding Developmental Center?
**PREGNANCY/BIRTH HISTORY:**

Name of hospital your child was born at: __________________________
City and State of Hospital: __________________________

Mother’s age at time of birth: ___________  Month prenatal care began: ___________

Amount of cigarettes smoked: __________________________

Dates smoked: __________________________

Amount of alcohol consumed: __________________________

Months drinking done: __________________________

Medications or Drugs taken: __________________________

(Other than vitamins & iron) __________________________

Months/Problems: __________________________

Illness during pregnancy: __________________________

Months/Problems: __________________________

___________________________________________

Length of pregnancy: ___________

Length of labor: ___________

Was labor induced?  ☐ NO  ☐ YES

Birth was: Normal (vaginal)  □  Cesarean  □  Breech  □  Twins or more  □

Were forceps used?  ☐ NO  ☐ YES

Mother’s complications (if any): __________________________

Birth weight: ___________

Apgar Scores: ___________

How long before the baby breathed without help? ___________

How long did baby stay on a ventilator? ___________

Why? ___________

How long did baby stay in the hospital after birth? ___________

Why? ___________

Was the baby transferred to another hospital after birth?  ☐ NO  ☐ YES

Where? ___________

Was baby jaundiced?  ☐ NO  ☐ YES

If yes, what kind and how long was treatment? ___________

Describe any other complications or problems: __________________________

___________________________________________

**CHILD’S DEVELOPMENTAL & MEDICAL HISTORY:**

**Medical:**

Check any of the following which pertain to your child, indicating age and complications:

<table>
<thead>
<tr>
<th>Age</th>
<th>Complications</th>
<th>Age</th>
<th>Complications</th>
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<tbody>
<tr>
<td>☐</td>
<td>Ear Infections</td>
<td>☐</td>
<td>Headaches</td>
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<td>☐</td>
<td>Fainting Spells</td>
<td>☐</td>
<td>Accidents</td>
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<tr>
<td>☐</td>
<td>Frequent Falls</td>
<td>☐</td>
<td>Thyroid Problems</td>
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<tr>
<td>☐</td>
<td>Strep Infections</td>
<td>☐</td>
<td>Visual Problems</td>
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<tr>
<td>☐</td>
<td>Diabetes/Hypoglycemia</td>
<td>☐</td>
<td>Hearing Problems</td>
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<tr>
<td>☐</td>
<td>Meningitis</td>
<td>☐</td>
<td>PE Tubes</td>
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<tr>
<td>☐</td>
<td>Seizures</td>
<td>☐</td>
<td>Other</td>
</tr>
</tbody>
</table>

Has your child ever been hospitalized for surgery or other problems?  ☐ NO  ☐ YES

If yes, then: When? ___________

Why? ___________

Where? (name and city of hospital) ___________

___________________________________________

Has your child been seriously sick, injured, or exposed to toxins or violence, but not hospitalized?  ☐ NO  ☐ YES

If yes, when, how, or with what? __________________________

___________________________________________

Does your child have any allergies (to medicines, foods, animals, etc.)?  ☐ NO  ☐ YES

If yes, to what and how does it affect him/her? __________________________

___________________________________________
List all medications your child currently takes or has taken for long periods of time in the past:

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>AMOUNT</th>
<th>REASON</th>
<th>WHEN TAKEN</th>
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</table>

Are you certain your child has all the necessary immunizations to keep him/her safe?  □ NO  □ YES
If no, then where do you get immunizations and what is missing? __________________________________________________________

What medical tests (like x-rays, EEG, blood tests, etc.) has your child had done in the past?  □ NONE
What test?  When done?  What result?  ________________________________________________________________

Growth & Development:

Motor Skills: At what age did your child...? (write “not yet” where appropriate)
Smile                    Roll Over                     Sit without support                    Hold a cup
Crawl                   Pull to Stand                  Walk Alone                     Hold a pencil
Pedal a Tricycle      a bicycle                        Hold a pencil correctly

What concerns, if any, do you have about your child's motor development? ____________________________________________

Language and Hearing: What age did your child...? (write “not yet” where appropriate)
Make single sounds        Use words        Combine words into short sentences
Does your child communicate mostly by: □ words  □ crying  □ phrases  □ sentences  OR □ gestures (like pointing, pushing, pulling, shrugging shoulders, nodding head, etc.)
Did your child begin to use words and then stop?  □ NO  □ YES  Stopped at what age? _______________________
What concerns, if any, do you have about your child’s speech, language, or hearing? ______________________________

Feeding: (write “not yet” where appropriate)
Was your child bottle fed? □ NO □ YES  Breast milk fed? □ NO □ YES  History of Reflux? □ NO □ YES
Did your child have changes in formula? □ NO □ YES  If yes, why:
For his/her age, is your child: □ average □ underweight □ overweight
For his/her age, is your child: □ average □ too short □ too tall
Has your child had any problems with: □ feeding □ chewing □ teeth □ swallowing
What eating problems or unusual food habits does your child have? ___________________________________________

Personal/Social: At what age did your child? (write “not yet” where appropriate)
Give up the bottle        Feed him/herself        Bladder train
Drink from a cup         Dress him/herself        Bowel train
Any problems with interaction and relations with other children or adults? __________________________________________

________________________________________________________

___________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________
Temperament, Emotion, and Behavior: (What kind of person was and is your child: easy/hard, sensitive/tolerant, quiet/loud, shy/outgoing, active/passive, happy/unhappy, etc. Describe any emotional or behavior problems that you or others see.)
As an infant:________________________________________________________________________
As a toddler:________________________________________________________________________
Preschool child _______________________________________________________________________
Elementary: _________________________________________________________________________
High School: _________________________________________________________________________

Sleep Habits:
As an infant:________________________________________________________________________
As a toddler:________________________________________________________________________
Preschool: __________________________________________________________________________
Elementary: _________________________________________________________________________
High School: _________________________________________________________________________

FAMILY MEDICAL/DEVELOPMENTAL HISTORY:
Biological Father’s Name ____________________________________________________________ Date of Birth ____________
First Last
Occupation __________________________________________________________ Employer _________________________________
Highest Grade Completed __________________________ Other Vocational Training ____________________________
Gross Annual Income* ___________ Home Phone # ___________ Cell # ____________________________

Biological Mother’s Name ____________________________________________________________ Date of Birth ____________
First Last
Occupation __________________________________________________________ Employer _________________________________
Highest Grade Completed __________________________ Other Vocational Training ____________________________
Gross Annual Income* ___________ Home Phone # ___________ Cell # ____________________________

Is the child Adopted? ☐ NO ☐ YES If so please fill out the following information:
Age at Adoption__________ Is the child aware he/she is adopted? ☐ NO ☐ YES
Adoptive-Father/Guardian ____________________________________________________________ Date of Birth ____________
First Last
Occupation __________________________________________________________ Employer _________________________________
Highest Grade Completed __________________________ Other Vocational Training ____________________________
Gross Annual Income* ___________ Home Phone # ___________ Cell # ____________________________

Adoptive-Mother/Guardian ____________________________________________________________ Date of Birth ____________
First Last
Occupation __________________________________________________________ Employer _________________________________
Highest Grade Completed __________________________ Other Vocational Training ____________________________
Gross Annual Income* ___________ Home Phone # ___________ Cell # ____________________________

Marital status of parents _____________________________________________________________ Date divorced, if applicable ________
Date of death of parent, if applicable ____________________________________ Which parent? ___________________________

How long has the family lived at the current address? ________________________________
Where else has the family lived during the child’s life? ________________________________
Indicate recent family stressors (financial concerns, births, deaths, marital conflicts, etc.): ________________________________
Indicate any Department of Human Services or other social service involvement: ___________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

List all persons living in the home:

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>RELATIONSHIP TO CHILD</th>
</tr>
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<tbody>
<tr>
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</table>

Family Interactions (How do you get along? How do you discipline? What family activities? etc.): 
____________________________________________________________________________________________
____________________________________________________________________________________________

Please note below if any of the child’s relatives (parent, brother, sister, aunt, cousin, etc.) have had any of the following conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relationship to Child</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convulsions (seizures)</td>
<td></td>
<td>Learning Problems</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td></td>
<td>Attention Problems</td>
</tr>
<tr>
<td>Muscle Weakness</td>
<td></td>
<td>Speech Problems</td>
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<tr>
<td>Muscle Tics (twitches)</td>
<td></td>
<td>Vision Problems</td>
</tr>
<tr>
<td>Tourette’s Syndrome</td>
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<td>Hearing Loss</td>
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<tr>
<td>Headache (migraine)</td>
<td></td>
<td>Intellectual Deficiency</td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td>Hyperactivity</td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td>Autism</td>
</tr>
<tr>
<td>HIV (Aids)</td>
<td></td>
<td>Anxiety</td>
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<tr>
<td>Skin Disease</td>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td>Other Mental Health Issues</td>
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<tr>
<td>Bone Disease</td>
<td></td>
<td>Legal Trouble (jail)</td>
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<tr>
<td>Stroke</td>
<td></td>
<td>Drug Addiction</td>
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<tr>
<td>Cancer</td>
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<td>Alcoholism</td>
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<tr>
<td>Thyroid</td>
<td></td>
<td>Violence</td>
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<tr>
<td>Diabetes</td>
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<td>Other</td>
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Describe any of the above: _____________________________________________________________________
____________________________________________________________________________________________

Siblings: Complete the following table for all of the mother’s pregnancies beginning with the first (including any miscarriages or stillbirths).

<table>
<thead>
<tr>
<th>Year of Pregnancy</th>
<th>Father’s Last Name</th>
<th>Length of Pregnancy</th>
<th>Length of Labor</th>
<th>Problems at Birth</th>
<th>Any physical, emotional, behavioral, or educational problems?</th>
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</table>

Siblings: Father’s children by other unions:

<table>
<thead>
<tr>
<th>Year of Pregnancy</th>
<th>Mother’s Full Name</th>
<th>Length of Pregnancy</th>
<th>Length of Labor</th>
<th>Problems at Birth</th>
<th>Any physical, emotional, behavioral, or educational problems?</th>
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</table>
SCHOOL HISTORY:
Please bring all old report cards, school achievement, and other testing results that you can find or get from the schools.

Preschool: Did your child attend a program or day treatment program?  ☐ NO  ☐ YES
If yes, where and for how long: __________________________________________________________

Home School: Is your child Home Schooled?  ☐ NO  ☐ YES  If yes, what curriculum is used: ________________________________

Kindergarten: Age began _________ Any Problems ____________________________________________

School Age:
List all schools attended:

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Grades Attended</th>
<th>Dates Attended</th>
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</table>

Has your child repeated a grade(s) or been held back:  ☐ NO  ☐ YES
If yes, which grade and why: __________________________________________________________

List extra-curricular, sport, or club activities of child: __________________________________________________________

Is your child currently receiving additional services through the school?  ☐ NO  ☐ YES
☐ Self-contained special education  ☐ Resource  ☐ Remedial/Chapter 1
☐ Speech/language therapy  ☐ Occupational therapy (OT)  ☐ Physical Therapy
☐ ABA Therapy  ☐ School Based Therapy  ☐ Other, please specify: ________________________________

Date of last school testing: _________ Results of testing: ____________________________________________
(Attach copies of testing if possible.)

Have you requested testing from the school?  ☐ NO  ☐ YES

Is any testing scheduled?  ☐ NO  ☐ YES  If yes, when? ____________________________________________

Are you satisfied with your child’s placement?  ☐ NO  ☐ YES  If no, why? ____________________________________________

What do you feel is your child’s main problem at school? ____________________________________________

What do you feel the school thinks is your child’s main problem? ____________________________________________
**PLEASE LIST THE NAMES AND ADDRESSES OF OTHER PROFESSIONALS WHO HAVE WORKED WITH YOUR CHILD BELOW AND ALSO ON YOUR AUTHORIZATION TO RELEASE INFORMATION FORMS (INCLUDED IN PACKET):**

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrician</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Speech Pathologist</td>
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<tr>
<td>Physical Therapist</td>
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<tr>
<td>Health Department (Nurse)</td>
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<tr>
<td>Mental Health Professional</td>
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<td>Specialist (please specify)</td>
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<td>Other (please specify)</td>
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</table>

I certify that the information I have provided is true and accurate to the best of my knowledge.

Signature: ___________________________  Date: ___________________________

Patient or Adult Legally Responsible for Minor Child Patient
AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, __________________________, hereby authorize Schmieding Developmental Center to release/request information from:

School District/Name: _____________________________________________________________

Address: _________________________________________________________________________

    Street Address    City    State    Zip

Phone: ___________________________   Fax: ___________________________

Information of:
Patient Name: ___________________________   DOB: ________________

The purpose of this authorization is for: _____ Payment   _____ Treatment   _____ Other: ____________________

Information to include:

☐ School Report
☐ Reports Card History
☐ Language Proficiency Testing
☐ Developmental/Psycho Ed Evaluation
☐ 504 Plan
☐ Behavior Evaluation/Plan
☐ Physical Therapy Evaluation
☐ Verbal Communication
☐ All Records
☐ Teacher Rating Form
☐ Achievement Test (Benchmark)
☐ MAC &/or ELDA Scores
☐ IFSP/IPP/IEP
☐ RTI / IRI Plan
☐ Speech Evaluation
☐ Occupational Therapy Evaluation
☐ Health Plan
☐ Other: __________________________

I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire ________________ (date) OR 1 year from date signed.

The facility, its employees, and clinicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations. I agree to pay the cost of copying, supplies, labor, postage, and other expenses associated with the request as allowed by law.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

________________________________________  ______________________  ______________
Legal Representative Signature  Relationship  Date
AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, ____________________________, hereby authorize Schmieding Developmental Center to release/request medical records, to include verbal communication, from the following individuals/clinics/hospitals:

PCP: ___________________________________________ Phone: __________________________

ENT: ___________________________________________ Phone: __________________________

Vision: _________________________________________ Phone: __________________________

Neurology: ______________________________________ Phone: __________________________

Genetics: ________________________________________ Phone: __________________________

Birth Hospital: _______________________________ Phone: __________________________

Mental Health: ________________________________ Phone: __________________________

ST, OT, PT: ______________________________________ Phone: _______________________

Other: __________________________________________ Phone: _________________________

Please list persons that may receive information (verbal or written) on behalf of your child.

Name_________________________________ Relationship_______________ Phone #_________________

Name_________________________________ Relationship_______________ Phone #_________________

Name_________________________________ Relationship_______________ Phone #_________________

Information of:
Patient Name: ___________________________________ DOB: __________________________

The purpose of this authorization is for: _____ Payment _____ Treatment _____ Other: ______________________

The purpose of this disclosure is for evaluating &/or treatment. I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire __________________ (date) OR 1 year from date signed.

The facility, its employees, and clinicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations. I agree to pay the cost of copying, supplies, labor, postage, and other expenses associated with the request as allowed by law.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

________________________________________ ________________________ __________
Legal Representative Signature Relationship Date

________________________________________ ________________________ __________
Witness Signature Relationship to Patient Date

REV. 02/17