Created to THRIVE

Developmental & Behavioral Pediatric Clinic

Free Pre-Consult Appointment: Brief Questionnaire

Accurately completing this Brief Questionnaire will provide Dr. Allen with valuable information that will help inform the type of Developmental & Behavioral Evaluation your child needs. Dr. Allen will supplement this Questionnaire during your pre-consult appointment so she can use all this information to craft the best possible Developmental & Behavioral Evaluation - unique to your child's specific needs. Once your child's consultation, and Dr. Allen's documentation, are complete, your child's formal Developmental & Behavioral Evaluation report will serve as a powerful tool in your hand – not just outlining a summary of your child's current developmental and behavioral strengths and weaknesses, but perhaps of greater import, the specific types of referrals, therapies, treatment modalities, and other supports and services that are most likely to benefit your child and help him/her thrive.

Dr. Allen provides comprehensive Treatment Recommendations that include: medical, developmental, behavioral, and educational recommendations. These recommendations will provide you with a "roadmap" to help you: (1) decide what medical referrals, tests, and/or treatments are most likely to benefit your child, (2) understand what therapies and services are needed to help your child continue to progress in their aquisition of new developmental milestones and address any behavioral concerns that may be present, (3) feel better equipped and empowered to help your child because of the advice shared during your consultation and your receipt of any necessary resources and supports that you may need, (4) work with your child's school to develop an educational plan that caters to your child's unique needs within the educational environment.

Congratulations on taking this important step to ensure your child's happiness and future well being!

Created to Thrive, PLLC Clinic Contact Information:
Address: 6922 West Rayford Rd, Suite 200, Spring, TX, 77389 | P: 346-808-5698 | F: 800-655-4148
Email: contact@createdtothrive.org Website: createdtothrive.org

Name of Person Completing this form & Relationship to patient: _____ _____

Patient's name: _____

Patient's DOB: _____ **Patient's gender:** _____

PRIOR EVALUATIONS:

Has your child received any prior developmental, behavioral, psychological, neuropsychological, or psychiatric evaluations? If so, please list the name(s) of the clinics/providers who performed these evaluations, when these evaluations were completed, and what diagnoses (if any) were provided.

Clinic &/or Provider Name:	**Date of Evaluation:**	**Diagnoses provided (if any):**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any current concerns you may have for the following:

☐ **Developmental delays** (please circle any/all that apply): gross motor, fine motor, speech/language, social-emotional

☐ **Autism Spectrum Disorder** ☐ **Attention Deficit Hyperactivity Disorder** ☐ **Learning Concern**

☐ **Anxiety** ☐ **Depression** ☐ **Other Mental Health / Psychiatric Concern**

☐ **Behavioral concerns** (check all that apply):

☐Aggressive behavior towards others ☐ Self injurious behaviors

☐Frequent &/or Prolonged Meltdowns (lasting ____ minutes, occuring ____ x per week)

☐ **Other (please explain below):** _____

EDUCATIONAL HISTORY:

Name of school or daycare that your child currently attends: _____

Current Grade Level (if applicable): _____

Has your child completed a Full Individual Evaluation (FIE) through any school district? Circle: YES or NO

If yes, when did he/she complete this evaluation? _____

If yes, what school district completed this evaluation? _____

Does your child receive any specialized support(s) in school (check all that apply):

☐ Individual Education Plan (IEP) ☐ 504 (Accommodation) Plan ☐ Behavior Intervention Plan

HISTORY OF MEDICAL THERAPIES & SERVICES:

What medical therapies and/or services has your child previously received AND what medical therapies and/or services is your child currently receiving?

Please check any/all that apply. Please indicate the approximate dates these therapies/services were received (approximate start & end date with mo/yr) and the frequency with which they were received (example: 1x/wk or 1x/mo).

Medical Therapies:	Clinic/Service Provider/School:	Start date:	End date:	Frequency:
__ Speech/language:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
__ Speech/feeding:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
__ Occupational therapy:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
__ Physical therapy:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
_ SST:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
_ V/I &/or O&M:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

HISTORY OF BEHAVIORAL THERAPIES & SERVICES:

What behavioral therapies and/or services has your child previously received AND what behavioral therapies and/or services is your child currently receiving?

Please check any/all that apply. Please indicate the approximate dates these therapies/services were received (approximate start & end date with mo/yr) and the frequency with which they were received (example: 1x/wk or 1x/mo).

Behavioral Therapies:	Clinic/Provider:	Start date:	End date:	Frequency:
__ Behavioral Modification Therapy	_____	_____	_____	_____
	_____	_____	_____	_____
__ Parent Child Interaction Therapy	_____	_____	_____	_____
	_____	_____	_____	_____
__ Parent Training	_____	_____	_____	_____
	_____	_____	_____	_____
__ Family &/or Child Counseling	_____	_____	_____	_____
	_____	_____	_____	_____

Is there anything else that you would like to share about your child, or about the concerns you have for your child?

_____

What are you hoping to learn, or gain, from your child's Developmental & Behavioral Evaluation?

_____

Best Telephone number & Time of day for us reach you: _____ _____

Please email or fax this completed form to:

Email: contact@createdtothrive.org

Fax: 800-655-4148

We look forward to contacting you to complete your free pre-consult appointment. This appointment will help determine if the type of evaluation that your child needs is within Dr. Allen's own scope of practice or if a different type of provider would be better suited to evaluate your child. Our goal is to ensure that your child receives the most appropriate evaluation – to best meet his or her needs!

Kind regards,

Candice Allen, MD
Developmental & Behavioral Pediatrician