GENERAL INFORMATION

Today's Date:_____

Child's Full Name:_____ Age: Date of Birth:_____

Address:_____ City State Zip_____

Name of person completing this form:

Which X&Y Chromosome Variation (i.e. XXY, XYY, XXYY, XXX) does your child have?_____

Child Was diagnosed: ☐Prenatally ☐before age 5 ☐age 5-11 ☐age 12-18 ☐after age 18

Does your child know his/her diagnosis? ☐Yes ☐No If no, do you plan to tell him/her before this appointment? ☐Yes ☐No

Approx. weight of child?_____ Approx. Height of child?_____

CURRENT FAMILY SITUATION

Mother's Name:_____ Age: Education:_____

Relationship to Child: ☐Natural Parent ☐Step-Parent ☐Adoptive Parent ☐Foster Parent

Address:_____ City State Zip_____

Home Phone:_____ Cell Phone: Work Phone:_____

Email Address:_____ Is email a reliable way to contact you? ☐Yes ☐No

Father's Name:_____ Age: Education:_____

Relationship to Child: ☐Natural Parent ☐Step-Parent ☐Adoptive Parent ☐Foster Parent

Address:_____ City State Zip_____

Home Phone:_____ Cell Phone: Work Phone:_____

Email Address:_____ Is email a reliable way to contact you? ☐Yes ☐No

With which parent(s) does the child live? ☐Both ☐Mother ☐Father ☐Other,_____

If Parents are separated or divorced, what year did this happen?_____ Who has custody of this child?_____

How often does the other parent see this child?_____

Do any other adults live in the home? ☐Yes ☐No If yes, Name, Age, Relationship:_____

How many other children are living in the home? (Please indicate if step-brothers/sisters or foster brothers/sisters)

Name and Age:_____

Name and Age:_____

Name and Age:_____

Name and Age:_____

Name and Age:_____

Is child adopted? ☐Yes ☐No If yes, Does child know they are adopted? ☐Yes ☐No

Age when child was first in home?_____ Date of Adoption?_____

Doctor's Name_____ Phone_____

Address:_____ City State Zip_____

IN THE SPACE BELOW, PLEASE DISCUSS YOUR PRIMARY CONCERNS AND/OR WHAT YOU PRIMARILY WISH TO TALK ABOUT DURING OUR APPOINTMENT(S) IN OUR CLINIC:

BIRTH INFORMATION

Was infant born full term? ☐Yes ☐No If premature, how early? _____ If late, how overdue? _____

Birth weight? _____ Type of Delivery? ☐Vaginal ☐Cesarean ☐Twins

Describe any complications during delivery: _____

Infant's APGAR scores (if known): _____ 1 minute _____ 5 minutes

Did infant have:

Breathing problems after birth?	☐Yes	☐No
Did infant require: Supplemental oxygen?	☐Yes	☐No
Breathing tube & Ventilator?	☐Yes	☐No
Did infant need bilirubin lights (for jaundice/yellow skin)	☐Yes	☐No
Did infant have seizures?	☐Yes	☐No
Did infant have bleeding into the brain?	☐Yes	☐No
Did physician express concern about brain damage?	☐Yes	☐No
Did infant require blood transfusions?	☐Yes	☐No
Did infant require X-rays/CT scan/ultrasounds?	☐Yes	☐No
Did the infant require the NICU (Neonatal Intensive Care Unit)	☐Yes	☐No

PREGNANCY INFORMATION

Mother's age during this pregnancy? _____ Father's age during this pregnancy? _____

Previous pregnancies? ☐Yes ☐No If yes, number of pregnancies (Including miscarriages, etc.) _____

Did mother receive prenatal care during the pregnancy? ☐Yes ☐No Starting in which month? _____

Did mother have any medical problems during or immediately before/after the pregnancy? (Vaginal infections, Urinary Tract Infections, Flus/Sore Throats, Seizures, High Blood Pressure, Diabetes, Premature labor, Anemia, Vaginal bleeding, Toxemia, Injuries, Emotional Problems?)

_____

_____

_____

_____

Were any of the following used during this pregnancy? (check all that apply)

☐ Medications. Please list: _____

☐Tobacco	☐Marijuana	☐Amphetamines	☐Methamphetamines
☐Cocaine	☐Alcohol	☐Other (specify)	
☐Heroin	☐Methadone		

DEVELOPMENTAL HISTORY

Age when child first rolled over?_____ ☐on time ☐late ☐don't remember

Age when child first sat alone?_____ ☐on time ☐late ☐don't remember

Age when child started walking independently?_____ ☐on time ☐late ☐don't remember

Is your child clumsy/uncoordinated? ☐Yes ☐No

Can your child use a pencil/crayon? ☐Yes ☐No

Can your child write his/her name? ☐Yes, at what age?_____ ☐No

Which hand does your child use for: Writing/drawing? ☐Right ☐Left Eating? ☐Right ☐Left

Age at child's first single words?_____ ☐on time ☐late ☐don't remember

What were his/her first words?_____

Age child spoke in 2 word-phrases?_____ ☐on time ☐late ☐don't remember

Age child spoke in sentences?_____ ☐on time ☐late ☐don't remember

Does child have difficulty with pronunciation/enunciation? ☐Yes, what sounds?_____ ☐No

Can child feed self? ☐Yes, at what age?_____ ☐No

Can child dress self? ☐Yes, at what age?_____ ☐No

Can child bathe self? ☐Yes, at what age?_____ ☐No

Can child help with household chores? ☐Yes, at what age?_____ ☐No

Does child know home phone number and address? ☐Yes, at what age?_____ ☐No

Can child tell time accurately? ☐Yes, at what age?_____ ☐No

Is child toilet trained? ☐Yes, at what age_____ ☐No

BEHAVIORAL/PSYCHOLOGICAL INFORMATION

Does your child currently have, or had in the past, any of the following behaviors on a regular basis.(Check all that apply)

- ☐ Temper tantrums/Oppositional behavior
- ☐ Impulsive
- ☐ Hyperactive
- ☐ Short attention span/distractible
- ☐ Repetitive Behaviors
- ☐ Perseveration (conversation fixed on specific idea/topics)
- ☐ Aggressive/destructive behaviors
- ☐ Hand flapping
- ☐ Rocking/spinning
- ☐ Nailbiting
- ☐ Picks/scratches body
- ☐ Poor coordination
- ☐ Bed wetting/soiling
- ☐ Daydreaming
- ☐ Poor eye contact
- ☐ Isolated/withdrawn
- ☐ Overly dependent/immature
- ☐ Low self-esteem
- ☐ Shyness
- ☐ Excessive worries/fears
- ☐ Doesn't like to be touched
- ☐ Bothered by things touching him (tags on his clothing, collars, belts, jewelry etc.)
- ☐ Motor tics
- ☐ Verbal tics
- ☐ Resistance to change in routine
- ☐ Cries often
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Reclusive/isolated behavior
- ☐ Moodiness/irritability
- ☐ Hallucinations (visual or auditory)
- ☐ Suicidal thoughts
- ☐ Sleep problems/Nightmares
- ☐ Masturbates excessively
- ☐ Self injurious (head bangs, bites/hits self)
- ☐ Obscene speech or unfiltered speech
- ☐ Fire setting
- ☐ Stealing/Lying
- ☐ Running away
- ☐ School refusal/truancy

BEHAVIORAL/PSYCHOLOGICAL INFORMATION (continued)

Eating behavior

☐Normal ☐Picky, Eats too little ☐Eats too much
Food Cravings? ☐Yes If yes, what foods? ☐No
Problems chewing/swallowing? ☐Yes ☐No
Other eating problems? _____

Social behavior

Does child make good eye contact?	☐Yes	☐No
Does child like to play with other children?	☐Yes	☐No
Does child have a fear of public places/crowds?	☐Yes	☐No
Does child have poor social skills?	☐Yes	☐No
Does child have friends?	☐Yes	☐No
Does child have frequent conflicts with peers?	☐Yes	☐No
Is child mean to others/bullying?	☐Yes	☐No
Is child a victim of bullying?	☐Yes	☐No
Has child's behavior resulted in problems at school?	☐Yes	☐No
Has child had any problems with the law?	☐Yes	☐No
Does child smoke, use alcohol, illegal drugs?	☐Yes	☐No

PREVIOUS PSYCHOLOGICAL & DEVELOPMENTAL EVALUATIONS

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

Who performed the previous treatments/evaluations/diagnostic tests? What were the results?
Please include provider name, date performed and results

☐Developmental Pediatrician _____
☐Neurologist _____
☐Psychologist _____
☐Psychiatrist _____
☐Speech-Language Therapist _____
☐Occupational Therapist _____
☐Physical Therapist _____
☐Mental Health Therapist/Counselor _____
☐Other _____

Has your child been previously been diagnosed with? (Please check all that apply)

- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Autism, Asperger's Syndrome, or Pervasive Developmental Disorder (PDD)
- ☐ Learning disability
- ☐ Reading disability
- ☐ Speech delay
- ☐ Mental retardation
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Sensory Integration Disorder
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Other behavorial, psychologic, or psychiatric disorder?

Has your child ever been hospitalized for psychiatric reasons? ☐No ☐Yes If yes, please explain (when, how long, where, did it help):

_____
_____
_____
_____
_____
_____
_____
_____

EDUCATIONAL HISTORY

Current School: ☐Private ☐Public Current Grade Level

School History (if none skip to next section) Does or did this child attend:

☐Early Intervention? If yes, at what age?
☐Preschool/Headstart? If yes, at what age?
☐Kindergarten? If yes, at what age?
☐Elementary/Middle school? If yes, at what age?

Has child ever repeated a grade? ☐Yes. What grade? ☐No

School Assessments and Intervention

Has child had special education testing in school?

☐ Psychological/Cognitive Date:
☐ Academic Date:
☐ Speech/Language Date:
☐ Other Date:

Does your child currently have an IEP? ☐Yes ☐No Previously had an IEP? ☐Yes ☐No if yes, when?

Special Education Classes/Services: Please check all that apply (Specifiy what grade/frequency/duration)

☐Special Education
☐Learning Disability
☐Speech/Language Therapy
☐Occupation/Physical therapy
☐Behaviorally/emotionally handicapped
☐Other health impaired
☐Other

Please list all other agencies and intervention services (e.g. speech therapy, OT, PT) involved with your family (e.g. Regional Center, Healthy Start, Child Protective Services, Early Intervention, etc.)

MEDICAL PROBLEMS/EVALUATIONS

During this child's first 3 years, were any special problems noted in the following areas?

☐Irritability
☐Difficulty sleeping
☐Difficulty feeding
☐Failure to thrive/poor growth & weight gain
☐Colic
☐Excessive crying

Does your child have other medical problems? Please check all that apply and explain, please include problems which have been treated in the past

☐ Ears? (Hearing problems, ear infections, etc.)
☐ Eyes? (Visual problems, strabismus, etc.)
☐ Dental? (Cavities, late tooth eruption, etc.)
☐ Neurologic Problems? (Seizures, tremors, brain malformations, abnormal muscle tone, etc.)

☐ Headaches? (Migraines, etc.)
☐ Lung problems? (Asthma, lung disease, breathing problems)

☐ Cardiovascular/Heart problems? (heart defects, murmurs, irregular rhythm, valve problem, circulation)

☐ High or low blood pressure?
☐ Stomach/Intestinal/Esophageal problems? (reflux/heartburn, ulcers, constipation, abdominal pain)

☐ Liver problems?
☐ Genitalia/Urologic Problems? (undescended/small testicles, problems with urination, hernia, infections)

☐ Abnormal Pubertal development? (early, delayed or abnormal puberty, gynecomastia/breast enlargement

☐ Thyroid problems?
☐ Diabetes?
☐ Orthopedic/Rheumatologic problems (Malformation of limbs/hands/feet, joint problems/pain, flat feet, etc.)

☐ Back problems? (scoliosis, kyphosis, other back abnormalities)
☐ Skin or Hair problems? (rashes, skin ulcers/sores, birthmarks, etc)

☐ Allergies? (food, environmental, medications)
☐ Blood problems (anemia, abnormal white blood cells, abnormal platelets)

☐ Frequent Infections? (skin, respiratory, urinary infections)

Has your child had any of the following diagnostic tests? (dates and results, if known)

☐EEG (brain wave test)
☐MRI
☐CT Scan
☐Blood Test (other than routine blood count)
☐Chromosomal/DNA testing
☐Vision Test
☐Other (specify)

Which other types of medical specialists have seen and evaluated/treated your child?

Has your child ever been hospitalized? ☐Yes ☐No
Has your child ever had surgery? ☐Yes ☐No
If hospitalized and/or surgery, when and why?

Please list all current medications and supplements:

Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?

FAMILY MEDICAL HISTORY

Mother: Health, learning, mental health problems? ☐Yes ☐No If yes, please describe:

Medications currently taking?

Number of Brothers: Number of sisters: Numbers of Nieces/Nephews:

Father: Health, learning, mental health problems? ☐Yes ☐No If yes, please describe:

Medications currently taking?

Number of Brothers: Number of sisters: Numbers of Nieces/Nephews:

Are there any medical illnesses in other family members? (Please specify who)

☐Birth defect	☐Diabetes	☐Mental Retardation
☐Speech/Language delay	☐High Blood Pressure	☐Learning Disability
☐Chromosomal disorder/genetic syndrome	☐Seizures	☐Depression
☐Autism/PDD	☐Kidney Disease	☐Anxiety Problems
☐Alcohol/Drug Abuse	☐Cancer	☐ADD/ADHD

☐Other: (Please describe)

Finding out about Sex Chromosome Aneuploidy

Today's date: _____

Child's birth date: _____

Child's current age: _____

Which type of SCA does your child have? (47,XXY; 47,XXX; 47,XYY, etc): _____

1. At what age did you first express concern (development, behavior, physical appearance) to your physician?

_____

2. Who first became concerns or suspected a diagnosis of SCA (parents, teachers, physicians, spouse)?

_____

3. What was the first concerning sign or symptom (development, behavior, physical)?

_____
_____
_____

4. If the concerning symptom was developmental delay, at what age did the professional confirm the child had delays?

_____

5. When did the child first receive early intervention therapies?

_____

6. How many times did you visit any doctor or health care professional about your concerns before chromosomal testing was ordered?

_____

7. Who first recommended a chromosome test (parents, teachers, friend, endocrinologist)?

_____

8. At what age was a chromosome test ordered? _____

9. At what age did you receive the SCA diagnosis? _____

10. Who made the diagnosis? (geneticist, endocrinologist, developmental pediatrician) _____

X&Y CHROMOSOME VARIATION MEDICATION PROFILE – PART ONE - CURRENT MEDICATIONS

PLEASE LIST THE MEDICATIONS YOUR CHILD IS CURRENTLY TAKING BELOW.

#1) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____ Which doctor started this medication?_____

Has the medication dosage been changed since the medication was started? ☐Yes ☐No

If yes, how has it changed? Why was it changed?

_____

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

_____

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same

☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:_____

_____

Does this medication have any side effects in your child? ☐Yes ☐No

If yes, please explain._____

#2) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____ Which doctor started this medication?_____

Has the medication dosage been changed since the medication was started? ☐Yes ☐No

If yes, how has it changed? Why was it changed?

_____

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

_____

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same

☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:_____

_____

Does this medication have any side effects in your child? ☐Yes ☐No

If yes, please explain._____

#3) Medication Name _____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____ Which doctor started this medication?_____

Has the medication dosage been changed since the medication was started? ☐Yes ☐No

If yes, how has it changed? Why was it changed?

_____

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

_____

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same

☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:_____

_____

Does this medication have any side effects in your child? ☐Yes ☐No

If yes, please explain._____

#4) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____ Which doctor started this medication?_____

Has the medication dosage been changed since the medication was started? ☐Yes ☐No

If yes, how has it changed? Why was it changed?

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same

☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:

Does this medication have any side effects in your child? ☐Yes ☐No

If yes, please explain.

#5) Medication Name

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started? Which doctor started this medication?

Has the medication dosage been changed since the medication was started? ☐Yes ☐No

If yes, how has it changed? Why was it changed?

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same

☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:

Does this medication have any side effects in your child? ☐Yes ☐No

If yes, please explain.

X&Y CHROMOSOME VARIATION MEDICATION PROFILE – PART TWO - PAST MEDICATIONS

PLEASE FILL OUT THE FOLLOWING ON ALL **PREVIOUS** MEDICATIONS WHICH WERE USED TO TREAT BEHAVIORAL, PSYCHOLOGICAL, NEUROLOGICAL, OR OTHER SIMILAR PROBLEMS. It is not necessary to fill this out for past antibiotics, etc.

#1) Medication Name_____
Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started?_____ Which doctor started this medication?_____
When was this medication stopped?
Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No
If yes, how was it changed? Why was it changed?

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

Did the medication help these symptoms?
- ☐ Yes – the symptoms significantly improved
- ☐ Yes – the symptoms slightly improved
- ☐ No – the symptoms were the same
- ☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

Why was this medication stopped?

Did this medication have any side effects in your child? ☐Yes ☐No
If yes, please explain.

#2) Medication Name_____
Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started?_____ Which doctor started this medication?_____
When was this medication stopped?
Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No
If yes, how was it changed? Why was it changed?

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

Did the medication help these symptoms?
- ☐ Yes – the symptoms significantly improved
- ☐ Yes – the symptoms slightly improved
- ☐ No – the symptoms were the same
- ☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

Why was this medication stopped?

Did this medication have any side effects in your child? ☐Yes ☐No
If yes, please explain.

#3) Medication Name_____
Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started?_____ Which doctor started this medication?_____
When was this medication stopped?
Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No
If yes, how was it changed? Why was it changed?

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

Did the medication help these symptoms?

☐ Yes – the symptoms significantly improved
☐ Yes – the symptoms slightly improved
☐ No – the symptoms were the same
☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

Why was this medication stopped?

Did this medication have any side effects in your child? ☐Yes ☐No
If yes, please explain.

#4) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started? Which doctor started this medication?
When was this medication stopped?
Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No
If yes, how was it changed? Why was it changed?

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

Did the medication help these symptoms?
☐ Yes – the symptoms significantly improved
☐ Yes – the symptoms slightly improved
☐ No – the symptoms were the same
☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

Why was this medication stopped?

Did this medication have any side effects in your child? ☐Yes ☐No
If yes, please explain.