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

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 ☐Alcohol

☐Other (cocaine, amphetamines, methamphetamines, heroin, methadone, or specify): ________________________

____

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.)

____

____

____

____

____

____

____

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
- ❑ Poor eye contact
- ❑ Isolated/withdrawn
- ❑ Overly dependent/immature
- ❑ 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)
- ❑ Sleep problems/Nightmares

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

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)
- ☐ Speech delay
- ☐ Developmental / Global delay
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Sensory Integration Disorder

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

If yes to any above, please describe:____

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?

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 – Prenatal Diagnosis

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. How far along was your pregnancy when your child's diagnosis was made? ______________________________________

2. What type of prenatal testing identified your child's diagnosis (NIPT, blood test, CVS, amnio, etc)?

   ____

3. What was the reason you had prenatal testing performed (maternal age, abnormal ultrasound findings, no reason, doctor offered, etc)?

   ____

4. What doctor ordered your prenatal testing (routine OBGYN, maternal fetal medicine doctor, IVF doctor, etc)?

   ____

5. Were you told about the possibility of finding this diagnosis prior to testing? ______________________________

6. Who provided you with information about the diagnosis? (routine OBGYN, maternal fetal medicine doctor, IVF doctor, genetic counselor, etc)?__

   ____

7. Did you ever meet or speak with a genetic counselor or genetic doctor after getting the diagnosis?___________________

   ____

8. How were you given information about the diagnosis? (in-person discussion, telephone conversation, written materials, etc)?

   ____
   ____
   ____

9. How much information was provided to you about the diagnosis when you were told?

   0 1 2 3 4 5 6 7 8 9 10
   Very Little ______ Adequate ______ A lot

   What information was provided?____
   ____
   ____

10. In your opinion, was the provider who gave you information about the diagnosis well informed about the condition?

   ____
   ____
   ____
   ____

11. Was this diagnosis tested for and confirmed after birth / postnatally in your baby? YES NO If yes, were results the same? YES NO

   ____

12. Other comments about your prenatal experience:_________________________________
   ____

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.

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

PLEASE FILL OUT THE FOLLOWING ON ALL **PREVIOUS** MEDICATIONS. 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.