**Lucile Salter Packard Children's Hospital**
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

Medical Record Number

Patient Name

Addressograph or Label

CLINIC VISITS • DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS •
DEVELOPMENTAL INTAKE QUESTIONNAIRE



***Office Use Only***
Date DBP Received Quest: ___/___/___
Medical Record #:_____

Name of person completing form:_____

Date form completed: ____/____/____

I. GENERAL INFORMATION

| | | | |
|---|---|---|---|
| CHILD'S NAME: | Last Name: | First Name: | |
| Date of birth: | / / | ❑ Male | ❑ Female |
| Mother's name / date of birth: | | / / | |
| Father's name / date of birth: | | / / | |
| Home address: | | | |
| Home phone & alternate phone #s: | | | |
| Second home address & phone # (specify parent): | | | |
| Child's primary language: | | | |
| Parents' primary language: | | | |

| | |
|---|---|
| Child's primary doctor: | |
| Primary doctor's address and telephone number: | |
| Other involved physicians: | |
| Other involved service providers: | |

| | |
|---|---|
| PRIMARY MEDICAL INSURANCE NAME: | |
| Address and telephone number (for us to contact for legibility): | |
| Name of Insured (father or mother): | |
| Policy ID Number: | |
| Group Number: | |
| Employer Name & City: | |
| SECONDARY MEDICAL INSURANCE NAME: | |

| | |
|---|---|
| CURRENT PROGRAM OR SCHOOL: | |
| Address and telephone number: | |
| Program/School Phone Number: | |
| Contact Person and phone #: | |

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## II. CONCERNS

What do you hope to accomplish during this visit?

_____
_____
_____

Main Concern: Please describe

_____
_____
_____

At what age did this problem first appear? _____

What have you done about this problem to date? _____
_____

Additional Concern 2: Please describe

_____
_____
_____

At what age did this problem first appear? _____

What have you done about this problem to date? _____
_____

Additional Concern 3: _____

_____
_____

At what age did this problem first appear? _____What have you done about this problem to date? _____
_____

## III. CURRENT FUNCTIONING

What are your child's interests or favorite activities?

_____
_____

What are your child's strengths?

_____
_____

How would you describe your child's abilities to:

Learn and use information, such as letters and numbers?

_____
_____

Handle various tasks and demands, including stressful or frustrating situations?

_____
_____

Communicate, verbally, non-verbally, and in writing?

_____
_____

Move about and manipulate objects?

Take care of him / herself, including eating, toileting, dressing, and getting to sleep?

Relate to others, including strangers, friends, peers, family members, and other adults?

Engage in Play?

Participate in community and social life, including play groups, classes or programs?

## IV. MEDICAL INFORMATION

### A. Pregnancy, Labor, and Delivery History (for child's mother to complete)

How many times have you been pregnant?_____ How many children do you have?_____
Birth order of this child?_____ How old were you when this child was born?_____

Were you healthy during the pregnancy of this child? ❑ Yes ❑ No
If no, please explain:_____

Were there medical or other problems during the pregnancy or delivery (❑ fertility treatment, ❑ procedures required, ❑ infections, ❑ unusual exposures)?
If so, please explain:_____

Did you have any of the following tests (❑ ultrasounds, ❑ amniocentesis, ❑ CVS, ❑ other) during the pregnancy? Were any of them abnormal?
Please explain:_____

Did you take ❑ prescription medications, ❑ herbal remedies, or ❑ over the counter medications in pregnancy?
Which ones?:_____

### B. Birth History

Name of the hospital child was born at:_____ City:_____

Was the baby premature? ❑ Yes ❑ No If so, _____ weeks gestation at birth
What was the mode of delivery? ❑ Vaginal ❑ Cesarean Section. Were there problems? ❑ No ❑ Yes
If yes, describe _____
Birth weight?_____ Apgars (if known)?_____

Did your child go to the special care nursery or NICU? ❑ Yes ❑ No. If so, why?_____

Did your child have any problems in the first few days of life? ❑ Yes ❑ No. If yes, describe. _____

_____

_____

Did your child have feeding problems as a newborn or infant? ❑ Yes ❑ No. If yes, describe. _____

_____

_____

How long did your child stay in hospital before going home? _____

C. Medical History

Please answer the following questions about your child's medical history.

| Has your child ever: | Date: | Reason and/or Results |
|---|---|---|
| Been to the emergency department? | | |
| Been hospitalized? | | |
| Had surgery? | | |
| Had any serious accidents? | | |
| Had any chronic medical concerns? | | |
| Had any allergies (food, medicine, airborne, etc.) | | |
| Had genetic testing? | | |
| Been to a neurologist? | | |
| Had an MRI or CT scan? | | |
| Had an EEG? | | |
| Had a hearing test? | | |
| Had his/her vision tested? | | |
| Had any other medical tests? | | |

Are your child's immunizations up to date? ❑ Yes ❑ No

D. Medication History

| Does your child take: | Current or past? | Which ones and why? |
|---|---|---|
| Prescription medications? ❑ Yes ❑ No | | Prescribed by: |
| Over the counter medications (including vitamins)? ❑ Yes ❑ No | | |
| Other biomedical/complementary / alternative treatments? ❑ Yes ❑ No | | Supervised by: |

V. FAMILY AND SOCIAL HISTORY

Who lives in the home?_____

_____

Is your child adopted? ❑ Yes ❑ No Are parents divorced? ❑ Yes ❑ No Are parents separated? ❑ Yes ❑ No

| Family Member | Age | Education level/ Grade in School | Occupation |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sibling 1 | | | |
| Sibling 2 | | | |
| Sibling 3 | | | |
| Other | | | |
| Other | | | |

Do any illnesses or conditions run in the family? ❑ Yes ❑ No If so, explain_____

_____

_____

Does anyone in your immediate or extended family have/or had any of the following problems?

| | | Family Member |
|---|---|---|
| Learning problems? | ❑ Yes ❑ No | |
| Attention Deficit Hyperactivity Disorder (ADHD)? | ❑ Yes ❑ No | |
| Depression, mental illness, anxiety, or other difficulties with their nerves? | ❑ Yes ❑ No | |
| Problems with muscles? | ❑ Yes ❑ No | |
| Language problems or talked late? | ❑ Yes ❑ No | |
| Intellectual Disability/ Global Developmental Delay/ Mental Retardation | ❑ Yes ❑ No | |
| Autism or a Pervasive Developmental Disorder? | ❑ Yes ❑ No | |

## VI. REVIEW OF SYSTEMS

Please circle any of the following problems that your child may have:

| | |
|---|---|
| General Health, energy, tiredness | Heart |
| Eyes / vision | Stomach / digestion |
| Ears / hearing | Stooling (constipation or diarrhea) |
| Snoring | Kidney / Urination (peeing) |
| Mouth / teeth | Muscles or bones |
| Swallowing / feeding | Head injury / seizures |
| Breathing | Birthmarks, freckles under arms or in the groin |
| Allergies | Hormones |
| Blood / sickle cell | Mental Health |

## VII. DEVELOPMENTAL HISTORY

At what age did you become concerned with your child's development?_____

What concerned you at that time?_____

_____

_____

Has your child ever lost skills? ❑ Yes ❑ No. If yes, when and what skills._____

_____

_____

Does your child prefer to use his/her (circle one): ❑ Right hand ❑ Left hand ❑ Both

Please give us information on the following milestones:

| | When did your child begin to (best memory is okay) | Comments |
|---|---|---|
| Sitting independently | | |
| Walking | | |
| Waving "bye-bye" | | |
| Pointing/Showing objects to others | | |
| First word | | |
| 2-word combination | | |
| Pretend/imaginary play | | |
| Toilet trained in daytime | | |
| Writes Name, letters and colors | | |
| Shows interest in counting | | |

VIII. PRESCHOOL/SCHOOL HISTORY:
Please list <u>past</u> preschools & schools attended:

| School name: | Dates (start-end): | Age: | Type of setting: |
|---|---|---|---|
| EXAMPLE: Rainbow Preschool | From June 2005-June 2006 | Ages 12-24 months | Community co-op preschool |
| | | | |
| | | | |
| | | | |

Current grade:_____ Type of class: ❑ Regular classroom ❑ Special classroom

Number of children in classroom:_____ Number of teachers in classroom:_____

IX. PREVIOUS EVALUATION AND SERVICE HISTORY
Please list below any testing done with a psychologist, speech and language pathologist, or other therapist.

| Test Done | With Whom | Where | When |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please indicate any services your child receives or has received in the past.

| Service Type | Dates of Service | Service Provider (if known) |
|---|---|---|
| Early Intervention / IFSP | | |
| Social Worker / Case Manager | | |
| Speech and Language Therapy | | |
| Occupational Therapy | | |
| Physical Therapy | | |
| Behavior Support Plan | | |
| Applied Behavior Analysis | | |
| Special Education / IEP | | |
| Mental Health Services | | |
| Public Health Services | | |

| | | |
|---|---|---|
| Learning Support (Tutor/Resource Specialist) | | List subject area: |
| Other Services | | Please list: |

Is / was your child qualified for services with the Regional Center? ❑ Yes ❑ No
Is / was your child qualified for Medical Therapy Program with CCS ❑ Yes ❑ No

Comments about your child's educational and/or intervention program:_____

_____

_____

Is there anything else you would like to share with us?_____

_____

**Dear parent,**

**Thank you for completing the Questionnaire. We would like to recommend that you please:**

- **Keep a copy for your records**
- **Contact your medical insurance company upon receipt of the Questionnaire to confirm whether or not an authorization for developmental assessment is needed**
- **Very important: If you have legal guardianship for this child, please include the legal documentation**

**We look forward to seeing you soon,**

**DBP Program**

_____ Date: _____

SIGNATURE (Patient, Parent or Properly Designated Representative)

PRINT NAME OF SIGNATOR :_____ RELATIONSHIP to Patient _____

| DATE TIME | Reviewed by (Signature): | | |
|---|---|---|---|
| | PRINT Name: | Credentials | Pager Number, if applicable |