# Developmental-Behavioral Pediatrics Questionnaire for New Patients

Date: _____ Name of person completing questionnaire:_____

Relationship to child: _____ Email:_____

**IDENTIFYING INFORMATION:**

| Information | |
|---|---|
| Child Name | |
| Child Birthdate | |
| Child Home Address | |
| Parent 1/Guardian Name | |
| Parent 2/Guardian Name | |
| Primary Doctor Name | |
| Referring Doctor Name | |
| School Name/Program | |
| Teacher & Grade | |
| School Contact | |

**CONCERNS:**

What is your main concern?

_____

_____

How old was the child when you first became concerned?

_____

_____

How can we help you?

_____

_____

What other concerns do you have about the child's behavior or development?

_____

_____

Has the child previously been evaluated for this concern or related concerns regarding development, behavior, or education? ☐Yes / ☐No

| Who did the evaluation? | Check Box | Date | What did they tell you? |
|---|---|---|---|
| Early Start or Regional Center | | | |
| School or IEP team | | | |
| Psychologist | | | |
| Education Specialist | | | |

| | | | |
|---|---|---|---|
| Therapist | | | |
| Other: | | | |
| Other: | | | |

Did the child have any delays in early development? ☐Yes / ☐No
Did the child ever show regression or lose skills they previously had? ☐Yes / ☐No

**How old was the child when the following skills appeared?**

| Skill | Age | Comments |
|---|---|---|
| Sitting without help | | |
| Walking | | |
| Saying first words | | |
| Making 2-word phrases | | |
| Using toilet in daytime | | |
| Showing pretend or imaginary play | | |
| Learning letters/numbers | | |
| Learning to read | | |

**ADAPTIVE FUNCTIONING:**

What does the child like to do? _____
What are the child's strengths? _____
What new skill(s) has the child learned in the past year? _____
What skill(s) has the child struggled to learn in the past year, despite attempts at teaching?
_____
_____

**Please tell us how this child compares to other children of the same age? Check the last column if you're not sure or the child is too young for o that skill.**

| Developmental Area | Far Behind | Slightly Behind | Same as others | Slightly Ahead | Far Ahead | Not sure/ too young |
|---|---|---|---|---|---|---|
| Learning | | | | | | |
| Reading | | | | | | |
| Writing | | | | | | |
| Math | | | | | | |
| Science | | | | | | |
| Social Studies | | | | | | |
| Art | | | | | | |
| Music | | | | | | |
| Handling tasks & demands | | | | | | |
| Communication or talking | | | | | | |
| Understanding direction | | | | | | |
| Mobility or walking | | | | | | |
| Athletics or sports | | | | | | |
| Ability to use hands & fingers | | | | | | |
| Taking care of self, such as dressing, bathing, etc. | | | | | | |
| Relating to close family | | | | | | |
| Relating to adults | | | | | | |
| Relating to other children | | | | | | |

**Do you have concerns in any of the following areas?**

| Area | | Describe |
|---|---|---|
| Eating, feeding, nutrition, including limited diet | ☐Yes / ☐No | |
| Toileting, including urine or stool accidents | ☐Yes / ☐No | |
| Sleeping, including difficulty falling asleep or snoring | ☐Yes / ☐No | |
| Intense or unusual interests | ☐Yes / ☐No | |
| Repetitive behaviors | ☐Yes / ☐No | |
| Other: | ☐Yes / ☐No | |
| Other: | ☐Yes / ☐No | |

**What services and supports is the child getting now?**

| Service | Age began | Provider and comments |
|---|---|---|
| Day Care or Preschool | | |
| Early Intervention, IFSP | | |
| Speech-Language Therapy | | |
| Occupational Therapy | | |
| Physical Therapy | | |
| Applied Behavioral Analysis, ABA | | |
| General Education | | |
| Special Education, IEP | | |
| Mental Health Services | | |
| Regional Center (over age 3 yrs) | | |
| Other: | | |

**PAST BIRTH AND MEDICAL HISTORY:**

Was child born near the due date (at term?) ☐Yes / ☐No If no, how many weeks gestation at birth? _____ How much did child weigh at birth? _____ How old was child's mother when the child was born? ____How many times has mother been pregnant? ____What birth order was this child? _____ Is this child a twin or triplet? ☐Yes / ☐No Name of twin (s): _____
Any problems during pregnancy? ☐Yes / ☐No If yes, describe:_____
Any problems during labor? ☐Yes / ☐No If yes, describe: _____
Any problems at delivery? ☐Yes / ☐No If yes, describe:_____
Was the child treated in the intensive care? ☐Yes / ☐No If yes, where:_____
Reason?_____

| Has child ever been | Date | Reason & results |
|---|---|---|
| To the Emergency Room | | |
| Hospitalized | | |
| Diagnosed with a chronic medical condition | | |
| In a serious accident | | |
| In Surgery | | |
| **Has the child been evaluated for** | | **Date of evaluation?** |
| Hearing | ☐Yes / ☐No | |
| Vision | ☐Yes / ☐No | |
| Genetic conditions | ☐Yes / ☐No | |
| Neurological conditions, such as seizures | ☐Yes / ☐No | |
| Other: | ☐Yes / ☐No | |

**MEDICATIONS:**

List all medications that the child is currently taking:_____
_____

List any complementary or alternative treatments the child is using:_____
_____

**ALLERGIES:**

Does the child have allergies? ☐Yes / ☐No If Yes, list: _____
_____

**SOCIAL HISTORY:**

Is the child adopted? ☐Yes / ☐No Are the parents divorced or separated? ☐Yes/ ☐No
Has your family ever had a significant stress, trauma, or loss that you think may have impacted the child? ☐Yes / ☐No Please briefly describe what, when, and is it over or ongoing?
_____
_____

Any details about your family you would like to share?_____
_____

**Who is in your family?**

| Family Member | Lives in home | Age | Name | Education | Occupation |
|---|---|---|---|---|---|
| Parent 1 | ☐Yes / ☐No | | | | |
| Parent 2 | ☐Yes / ☐No | | | | |
| Sibling 1 | ☐Yes / ☐No | | | | |
| Sibling 2 | ☐Yes / ☐No | | | | |
| Sibling 3 | ☐Yes / ☐No | | | | |
| Other: | ☐Yes / ☐No | | | | |
| Other: | ☐Yes / ☐No | | | | |
| Other: | ☐Yes / ☐No | | | | |
| Other: | ☐Yes / ☐No | | | | |

**FAMILY MEDICAL HISTORY:**

**Does anyone in the family have (or had) any of the following conditions?**

| Condition | | Which family member? |
|---|---|---|
| Developmental delays | ☐Yes / ☐No | |
| Delays in language/talked at late age | ☐Yes / ☐No | |
| Learning problems, such as dyslexia or poor reading | ☐Yes / ☐No | |
| Intellectual disability/Global delays | ☐Yes / ☐No | |
| Autism | ☐Yes / ☐No | |
| Attention deficit (ADHD) | ☐Yes / ☐No | |
| Depression or anxiety, including suicide | ☐Yes / ☐No | |
| Schizophrenia or bipolar disorder | ☐Yes / ☐No | |
| Tics or Tourette syndrome | ☐Yes / ☐No | |
| Genetic disorder or birth defect | ☐Yes / ☐No | |

| | | |
|---|---|---|
| Seizure or epilepsy | ☐Yes / ☐No | |
| Addiction or alcoholism | ☐Yes / ☐No | |
| Cardiac disease, including sudden death | ☐Yes / ☐No | |
| Other: | ☐Yes / ☐No | |
| Other: | ☐Yes / ☐No | |

**REVIEW OF SYMPTOMS**:

**Other than the information you have already provided, does the child have any other conditions?**

| Condition or body area or function | | Describe |
|---|---|---|
| General health, such as energy level, difficulty gaining weight, or overweight | ☐Yes / ☐No | |
| Eyes or vision | ☐Yes / ☐No | |
| Ears or hearing | ☐Yes / ☐No | |
| Mouth or teeth | ☐Yes / ☐No | |
| Breathing or respiration, including asthma | ☐Yes / ☐No | |
| Heart or cardiovascular/circulation | ☐Yes / ☐No | |
| Digestion/stooling or gastrointestinal, including recurrent vomiting | ☐Yes / ☐No | |
| Elimination/urination/peeing or genitourinary | ☐Yes / ☐No | |
| Muscles/bones or Musculoskeletal | ☐Yes / ☐No | |
| Nerves/brain or Neurological, such as staring spells, shaking, or seizures | ☐Yes / ☐No | |
| Skin, including eczema, birthmarks or rashes | ☐Yes / ☐No | |
| Allergy or immunological | ☐Yes / ☐No | |
| Endocrine or hormones | ☐Yes / ☐No | |
| Blood or hematologic | ☐Yes / ☐No | |
| Mental health or psychiatric | ☐Yes / ☐No | |
| Behavior, including lying, stealing, setting fires, or cruelty to animals | ☐Yes / ☐No | |

**ADDITIONAL INFORMATION:**

Is there anything else you would like us to know before the child's visit?

_____

_____

Thank you for completing this form!

**Please return completed form by Mail or Fax to:**

**Development & Behavior Department**
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