DEVELOPMENTAL PEDIATRICS

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NEW PATIENT INTAKE QUESTIONNAIRE

Please carefully read & complete all sections of this form.

DEMOGRAPHIC INFORMATION

Today's date: ________________ Person completing this form and relation to the child: ________________________________

Child's Name: ____
Last Name First Name Middle initial

Birth date: ____________________ Age: _______ Sex: ○ Male ○ Female

Contact information: ______________________ ____________________ ______________________________________
Home/Cell Work Email

Child's primary health care provider: ____________________________ Who recommended this evaluation? __________________

WHEN DID YOU FIRST BECOME CONCERNED ABOUT YOUR CHILD AND WHY?

____
____
____
____

PLEASE STATE THE MAIN CONCERN(S) OR REASON(S) FOR SEEKING HELP AT THIS PARTICULAR TIME:

____
____
____
____

WHAT SPECIFIC QUESTIONS WOULD YOU LIKE ANSWERED BY THIS EVALUATION?

1.____
2.____
3.____

HAS YOUR CHILD EVER BEEN EVALUATED FOR THIS PROBLEM BEFORE? ○ Yes ○ No If yes, by whom and when?

____
____

PLEASE LIST NAMES OF OTHER PROFESSIONALS WHO HAVE EVALUATED YOUR CHILD AND ANY DIAGNOSES PROVIDED: (Examples: ENT, Neurologist, Psychiatrist (MD), Psychologist (Ph.D.), Social Worker, Counselor, Geneticist, Physical Medicine & Rehabilitation, Developmental Pediatrician)

____
____

PLEASE LIST ANY STRESSFUL AND/OR TRAUMATIC FAMILY EVENT IN YOUR CHILD'S LIFE WHICH YOU FEEL MAY HAVE AFFECTED HIM/HER:
(Examples: parent deployment, PCS, birth of a sibling, death in the family, divorce, illnesses, frequent school changes, abuse)

EVENT	CHILD'S AGE	COMMENTS

BEHAVIORS OF CONCERN:

****Please check any of the following which are concerning or unusual (when compared to children of the same age as your child)*

○ Short attention span ○ Poor concentration ○ Poor organization skills ○ Incomplete tasks or assignments ○ Distractible ○ Restless, fidgety ○ Hyperactive ○ Impulsive ○ Attention-seeking	○ Excessive anxiety/worry ○ Unusual fears/worries ○ Stranger anxiety ○ Social anxiety ○ Frequently sad ○ Depressed ○ Withdrawn ○ Shy ○ Low self-esteem ○ Bullied by others ○ Hears or sees things others do not	○ Unusual tantrums/meltdowns ○ Aggressive behavior ○ Abrupt/frequent mood swings ○ Angry ○ Excessive irritability ○ Fighting ○ Defiance ○ Lying ○ Stealing ○ Other: ___________________________	<u>Academic Concerns</u> ○ Reading ○ Spelling ○ Hand writing ○ Fine motor skills ○ Math ○ Speech ○ Written expression
○ Aloof/indifferent to others ○ Rarely responds to name ○ Does not imitate what others are doing ○ Does not respond to praise ○ Unusual eye contact ○ Does not use common gestures (e.g., pointing, waving, shaking head "no") ○ Prefers to play alone ○ Does not play pretend with toys	○ Unusual repetitive behaviors (hand-flapping, toe-walking) ○ Repetitive speech ○ Repetitive play ○ Difficulty/meltdowns with change in routines or during transitions ○ Resists change ○ Severe separation anxiety ○ Unusual routines or rituals ○ Obsessions ○ Limited range of food preferences ○ Unusual interests _____________	○ Looks at objects in unusual ways ○ Upset by loud, sudden noises ○ Smells, sniffs food/people/objects ○ Mouths/chews objects or toys ○ Upset by clothing textures ○ Dislikes being touched ○ Seeks deep pressure/squeezes ○ Frequently spins or paces ○ Lack of response to pain	<u>Sleep</u> ○ Difficulty falling asleep ○ Difficulty staying asleep ○ Snoring ○ Gasping breaths ○ Night terrors ○ Other: ___________________

PEER RELATIONSHIPS & SOCIAL SKILLS

Does your child have opportunity to be around other children of the same age? ○ Yes ○ No

Does your child have trouble making or keeping friends? ○ Yes ○ No *If yes, please explain:* ____

With whom does your child <u>prefer</u> to play? ○ Alone ○ Family members only ○ Adults ○ Younger children ○ Older children ○ Same-age children

INTERESTS & ACCOMPLISHMENTS OF YOUR CHILD

What are your child's favorite toys, games, hobbies, and interests? ____

Clubs, sports, recreational activities: ____

What does your child do best? ____

THERAPIES & EDUCATIONAL INTERVENTIONS

THERAPY OR SERVICE	EARLY INTERVENTION (IN HOME)	SCHOOL	CLINIC	CURRENTLY?	NEVER
Physical Therapy	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐
Speech Therapy	☐	☐	☐	☐	☐
ABA Therapy		☐	☐	☐	☐
Counseling		☐	☐	☐	☐
Special Education		☐		☐	☐

SCHOOL

Current grade: _____ Name of school: ____ City: _________________________

SPECIAL EDUCATION SERVICES (PAST OR PRESENT)

Does your child have an INDIVIDUALIZED EDUCATION PROGRAM (IEP)? ○ Yes ○ No *If yes, what category?*

○ Developmental Delay (DD) ○ Intellectual Disability ○ Autism ○ Emotional Disability (ED)
○ Speech/Language Impairment ○ Hearing Impairment ○ Visual Impairment ○ Specific Learning Disability
○ Other Health Impairment (OHI) ____________________________

What is your child's CURRENT CLASSROOM SETTING?

○ Preschool program ○ Self-contained (all day) ○ Inclusion classroom ○ General education ○ SECEP

Does your child have a 504 ACCOMMODATION PLAN? ○ Yes ○ No *If yes, please describe:* __________________________

SOCIAL HISTORY

List all people living in house (If joint custody, please include all households)

NAME	RELATIONSHIP	AGE	HIGHEST EDUCATION LEVEL/GRADE OCCUPATION
			Highest Education Level: __________ Occupation: ___________________
			Highest Education Level: __________ Occupation: ___________________
			Highest Education Level: __________ Occupation: ___________________
			Highest Education Level: __________ Occupation: ___________________
			Highest Education Level: __________ Occupation: ___________________
			Highest Education Level: __________ Occupation: ___________________
			Highest Education Level: __________ Occupation: ___________________

Biological parents' marital status: ☐ Married (Years: ________) ☐ Separated ☐ Divorced ☐ Never Married
Is your child adopted? ☐ No ☐ Yes If yes, does your child know his/her adoption status: ☐ No ☐ Yes

Sponsor's military status: ☐ Active Duty ☐ Reserve ☐ Retired/separated ☐ Federal Employee

Branch of Service: ☐ Air Force ☐ Army ☐ Coast Guard ☐ Navy ☐ Marines
Sponsor's Specific Job: ____

Deployment: ☐ N/A Most recent dates: _____to _____
Arrival to Current Base (mo/yr): __________ Expected departure/PCS (mo/yr): ___________ ☐ N/A

Is your child enrolled in the Exceptional Family Member Program (EFMP)? ☐ No ☐ Yes

Is your child enrolled in TRICARE's Extended Care Health Option (ECHO)? ☐ No ☐ Yes

Does your child receive any of the following services? ☐ Medicaid Waiver ☐ SSI ☐ Respite care

FAMILY HISTORY

Please identify any family medical history

Illness	Mother	Father	Patient's Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Deceased							
- Cause of death							
ADHD/ADD							
Aggressiveness							
Alcohol or Drug Abuse							
Antisocial Behavior (assaults, thefts, arrest, jail)							
Anxiety disorder							
Autism Spectrum Disorder (including Asperger disorder and Pervasive Developmental Disorder/PDD)							
Bipolar Disorder/Manic depressive							
Blindness							
Cerebral palsy							
Conduct disorder							
Deafness (from birth)							
Depression							
Genetic disorder (inherited disorders or problems)							
Heart rhythm problems							
Intellectual disability (cognitive impairment, mentally challenged)							
Learning disability (math, writing, reading)							
Oppositional Defiant Disorder							
Psychosis							
Schizophrenia							
Seizure disorder							
Tourette Syndrome (Tic Disorder)							

PAST MEDICAL HISTORY

Major medical problems: ☐ None ☐ Yes (specify): ______________________
Hospitalizations: ☐ None ☐ Yes (specify): ______________________
Surgeries: ☐ None ☐ Yes (specify): ______________________
Serious accidents or injuries: ☐ None ☐ Yes (specify): ______________________

Has your child had a hearing test? ☐ No ☐ Yes (date): ____________ Results: ____________
Has your child had a vision test? ☐ No ☐ Yes (date): ____________ Results: ____________

Please list **current** medications:

NAME OF MEDICATION	DOSE/FREQUENCY	BENEFITS, CONCERNING SIDE EFFECTS?
Please list **current** vitamins, supplements, complementary/alternative treatments (e.g., melatonin, etc.)		

PRENATAL HISTORY

Mother's age at delivery: ____ Father's age at delivery: ____

Number of pregnancies *before this* child: ____ Number of children born *before this* child: ____

List any complications or illnesses which occurred during this pregnancy: ____________________

List prescribed medications taken during this pregnancy: ____________________

List any over-the-counter medications taking during this pregnancy: ____________________

Did the mother drink any alcohol during this pregnancy? ☐ No ☐ Yes ☐ Suspected ☐ Unknown

Did the mother use tobacco products during pregnancy? ☐ No ☐ Yes ☐ Suspected ☐ Unknown Packs per day: ______

Did the mother take any illegal/street drugs during pregnancy? ☐ No ☐ Yes ☐ Suspected ☐ Unknown

BIRTH/NEWBORN HISTORY

Was the baby born on time (term gestation)? ☐ Yes ☐ No *Number of weeks born: early* ___ *late* ___

What was the reason for preterm or early birth (if known)? ____________________

Type of delivery: ☐ vaginal ☐ cesarean section (C/S) ☐ forceps ☐ vacuum extraction

Reason for delivery <u>if not</u> vaginal or repeat C/S: ____________________

Baby's birth weight: ________ APGAR scores (if known): ___at 1 minute ___at 5 minutes

Did the baby spend time in the special care nursery or NICU following birth? ☐ No ☐ Yes (please explain):

____

Passed newborn hearing screen: ☐Yes ☐No Passed newborn metabolic screen (PKU screen): ☐Yes ☐No

How many days old was your baby when discharged from the hospital? ____

CHILD'S TEMPERAMENT DURING THE FIRST MONTHS OF LIFE:

Enjoyed being held or cuddled? ☐ Yes ☐ No Difficult to calm or console? ☐ No ☐ Yes

Excessive irritability or fussiness? ☐ No ☐ Yes Difficulty developing a predictable routine? ☐ No ☐ Yes

DEVELOPMENTAL MILESTONES

ANY HISTORY OF LOST SKILLS OR MILESTONES? (***skills which your child was consistently doing, not just once or twice***) ○ NO ○ YES IF YES, PLEASE EXPLAIN:

____

WHAT AGE DOES YOUR CHILD MOST ACT LIKE? (***the age your child acts the majority of the time***) ____________________

PLEASE INDICATE THE APPROXIMATE AGE WHEN YOUR CHILD WAS CONSISTENTLY ABLE TO DO THE FOLLOWING:

GROSS MOTOR MILESTONES *(indicate age in months or years)*	**AGE**	**FINE MOTOR/SELF-HELP MILESTONES** *(indicate age in months or years)*	**AGE**
• Rolled over	___ months	• Used fingers to feed self	___ months
• Sat with support	___ months	• Fed self with a spoon	___ months
• Crawled	___ months	• Undressed self	___ months
• Walked independently	___ months	• Dressed self	___ months
• Pedaled a tricycle	___ months	• Toilet trained	___ months
• Rode a bicycle without training wheels	___ years		

LANGUAGE MILESTONES *(indicate age in months or years)*	**AGE**	**SOCIAL MILESTONES** *(indicate age in months or years)*	**AGE**
• Babbled (mamama, babababa)	___ months	• Smiled to get your attention	___ months
• Waved “bye bye”	___ months	• Looked when you called his name	___ months
• Said first word (other than “mama” or “dada”)	___ months	• Showed you an object he likes	___ months
• Pointed to pictures in a book when asked	___ months	• Pointed to ask for something	___ months
• Said 2 words together (e.g., “more milk”)	___ months	• Pointed to show something she likes	___ months
• Pointed to body parts when asked to show them	___ months	• Hugged a doll or other toy (pretend play)	___ months
		• Noticed when others were hurt or upset (e.g., pausing or looking sad when someone is crying)	___ months

Is there any additional information you would like us to know about your child?

Thank you for completing this questionnaire.

We look forward to meeting you and your child soon!