COLLABORATIVE MOTOR CLINIC

NAVAL MEDICAL CENTER PORTSMOUTH
NEURODEVELOPMENTAL PEDIATRICS
NEW PATIENT QUESTIONNAIRE

Dear Parents and Caregivers,

Welcome to Neurodevelopmental Pediatrics! Please complete this form to help us understand your questions and concerns about your child. Thank you for your efforts-this will be helpful during your visit. If there are questions you aren't sure about, just do the best you can.

Child's Name: ____________________________
Child's Date of Birth:______________________
Child's PCM:_____________________________
Child's School or School District:_____________
Email we may use to contact you:
____

Your name:_______________________
Today's Date:______________________
Phone Number:_____________________

If your child has been evaluated before, **please bring all evaluations with you.** This is *very important* and will help us to provide an accurate and appropriate evaluation for your child.

- ☐ Psychological/School testing
- ☐ Occupational, Physical, and Speech Therapy Evaluations
- ☐ Individual and Family Service Plans
- ☐ Individualized Education Plans
- ☐ Medical Evaluations (especially from civilian providers)

REASONS FOR EVALUATION

Please list the problems, questions or concerns for which you want help for your child:

What are your goals for today's visit?

CURRENT ABILITIES/FUNCTIONING

Mobility:

How does your child get around?:

At home:

In the community:

Spasticity:

Is your child having difficulty with stiffness or muscle tightness? □ Yes □ No

Location:

Has your child ever been treated for spasticity and what was the response?

Medication	□ Yes □ No	Response:
Botox	□ Yes □ No	Response:
Surgery	□ Yes □ No	Response:
Bracing	□ Yes □ No	Response:

Activities of Daily Living:

How does your child meet basic needs for dressing/bathing?:

- Dependent for all care
- Needs assistance
- Independent

How does your child use the toilet?:

- Diapered. If so, where do you get diapers?:
- Uses toilet with help
- Uses toilet independently

How does your child eat?:

- By mouth fed by another person
- By mouth independently
- By mouth and tube
- By gastrostomy/jejunostomy/nasogastric tube (circle one)
- Other:

Is there any choking or coughing associated with eating or drinking: □ Yes □ No

How does your child communicate wants and needs?

- ☐ Noises
- ☐ Words
- ☐ Signs
- ☐ Facial Expressions

What concerns do you have about your child's language ability?:

- ☐ Understanding spoken directions
- ☐ Expressing him/herself verbally
- ☐ Speaking clearly
- ☐ Back and forth conversation skills

Participation: What activities does your child enjoy or participate in at home or in the community?

Education: Are you or your child's teachers concerned about your child's ability to learn new information or to perform at school/daycare? ☐ Yes ☐ No

Specify:

Does your child currently have any of the following?:

- ☐ Individual and Family Service Plan
- ☐ Individualized Education Plan
- ☐ 504 plan

Therapies:

Check therapies your child receives at school and in the community:

	School/Early Intervention	Community (List Agency)
Physical		
Occupational		
Speech		
Other		

Do you have concerns about social development/behavior (please specify):

- ☐ Social skills/Friendships:
- ☐ Activity level/Attention and concentration:
- ☐ Aggression towards self/others:
- ☐ Anxiety/Sadness:

Adaptive equipment:

Does your child need any adaptive equipment at this time?

What adaptive equipment does your child use at this time (please specify):

- ☐ Splints/braces:
- ☐ Wheelchair/Stroller:
- ☐ Walker:
- ☐ Stander:
- ☐ Bath chair:
- ☐ Communication device:

Military and community supports:

Does your child have any of these supports?:

- ☐ Enrollment in Exceptional Family Member Program (EFMP)
- ☐ Enrollment in ECHO
- ☐ Case management: Please provide name and agency:
- ☐ Respite care
- ☐ Medicaid
- ☐ SSI

Transition to adulthood:

What concerns do you have about your child as he/she approaches adulthood?

DEVELOPMENTAL HISTORY

When were you first concerned about your child's development?
Has your child ever **lost** any skills? ◻ Yes ◻ No (If yes, please explain):

When did your child first do the following?

Motor skills	**Age**	**Language**	**Age**
Sat unsupported		Coo	
Crawled		Babble	
Walked alone		Wave bye-bye	
Pedaled Tricycle		Said "mama/dada"	
Bicycle with/without training wheels	/	2-word combinations/3-word sentences	/
Self-Care	**Age**	**Learning**	**Age**
Fed self with a spoon		Knew colors	
Removed clothes		Recited alphabet	
Put on clothes		Wrote name	
Toilet trained			
Tied shoes			

Temperament: these questions are about ***how*** your child has since birth:

Activity level ☐ Always moving and active ☐ Still and calm Sleep, appetite, bowels ☐ Predictable ☐ Less Predictable Adaptation to changes in routine or daily activities ☐ Flexible ☐ Inflexible React to new people or unfamiliar situations ☐ Warms up with time ☐ Warms up quickly Sensitivity to: sounds, touch, clothing ☐ Sensitive ☐ Less sensitive	Intensity of feelings or emotions (either positive or negative) ☐ Intense response ☐ More reserved response Distractibility ☐ Easily changes focus ☐ Pays attention Usual mood ☐ Pleasant and cheerful ☐ More critical/analytical Persistence ☐ Sticks with tasks/activities ☐ Moves on if tasks are difficult or frustrating

MEDICAL HISTORY

Early Medical History (Pregnancy, Birth, Infancy)	
Pregnancy	
Was there any difficulty getting pregnant or any fertility treatments? □ Yes □ No • Please list the treatments used: Number of prior pregnancies: ____ Mother's age during pregnancy: ____ Father's age during pregnancy: ____ When did prenatal care begin? □ First Trimester □ Second Trimester □ Third Trimester □ No prenatal care Length of pregnancy: Were there any complications during pregnancy? Mother's weight gain during pregnancy: □ too little □ just right □ too much Mother's health during pregnancy: □ Good □ Fair □ Poor Please list **ALL medications/supplements** taken during pregnancy:	Did mother drink alcohol or use drugs in the months prior to discovering pregnancy? □ Yes □ No Please list amount per day of the following *during pregnancy*: Beer or wine: Hard liquor: Cigarettes: Drugs (specify): Did mother have any of the following problems during pregnancy (check): □ Vaginal bleeding or spotting □ Prenatal monitoring or test (amnio, stress test, ultrasound) □ Hospitalization □ Diabetes □ Fever, Rash, Infection (Rubella, CMV, HIV) □ Serious Injury or Surgery □ Seizures or convulsions □ Stresses or worries (Specify): □ Other problems: Baby's movements in utero were: □ very little □ average □ very active

Labor and Delivery/Neonatal Period

Labor:
How long was labor?

Were there complications during labor or delivery?
□ Yes □ No

If yes, what?

- □ Premature rupture of membranes
- □ Abnormal bleeding
- □ Forceps/vacuum
- □ Baby required oxygen or resuscitation
- □ Failure to progress
- □ Maternal fever
- □ Other problems:

Type of Delivery:
□ Vaginal □ C-Section

Baby's position

- □ Head down (vertex)
- □ Legs or bottom down (breech)

Birth Weight __________ Length____________
Head circumference_______________

How long did your baby stay in the hospital after birth?

How long did the mother stay in the hospital after birth?

Did the baby spend time in the NICU?
□ Yes □ No

Problems in the newborn period?

Did your baby pass a newborn hearing test?
□ Yes □ No

Feeding

- □ Breast Fed until
- □ Bottle Fed until
- □ Difficulty with feeding (please explain):

Was there a history of post-partum depression?
□ Yes □ No □ Maybe, not officially diagnosed

What was the child like as a baby (easy to soothe, difficult to soothe, content, fussy, irritable, challenging, quiet…)

Childhood Medical History

Has your child had any **chronic** or severe illnesses or medical problems? □ Yes □ No
Please list and explain:

1.
2.
3.

Has your child ever been hospitalized? □ Yes □ No
Please explain:

Has your child ever had surgery? □ Yes □ No
Please explain:

Allergies (medication, food, environmental, seasonal):
□ No allergies □ Allergies to:

Are immunizations up to date?
□ Yes □ No If no, why not?

Medications
Please list your child's current medications:
1.
2.
3.
4.

Review of Systems

Nutrition: Are you concerned about your child's eating habits or growth?: □ No □ Yes
Please check specific concerns:
- □ Eats too much
- □ Eats too little
- □ Too picky
- □ Other:

Sleep: Does your child have any trouble with sleep?: □ Yes □ No
What time does your child get in bed? ___________
What time does your child fall asleep? ___________
Does your child wake up during the night? □ No □ Yes
Is there snoring? □ No □ Yes
Are there pauses in breathing □ No □ Yes

Elimination: How often does your child have a **bowel movement**?
____
Is it:
- □ Too hard
- □ Too soft
- □ Average

Are there any accidents with stooling? □ No □ Yes

Does your child have any **trouble with urination** or **bladder problems**? □ No □ Yes
Please check specific concerns:
- □ Accidents during the day
- □ Accidents at night
- □ Other:

Does your child have (check if yes and please explain):

- ☐ Skin problems
- ☐ Birth marks
- ☐ Bone/muscle/joint problems
- ☐ Headaches
- ☐ Seizures
- ☐ Head too small/too big/odd shape?
- ☐ Vision/eye problems?
- ☐ Hearing/ear problems?
- ☐ Nose problems?
- ☐ Breathing problems (wheezing, cough or other)
- ☐ Neck Problems
- ☐ Stomach/Intestinal problems?
- ☐ Other:
- ☐ CHECK HERE IF YOUR CHILD HAS NONE OF THE PROBLEMS LISTED ABOVE

SOCIAL HISTORY:

Mother's Name:_______________________ Date of Birth:_________________ Education Level:______________ Occupation:__________________ Marital Status:________________	**Father's** Name:_______________________ Date of Birth:_________________ Education Level:______________ Occupation:__________________ Marital Status:________________
Who lives with the child at home? (Name, Age, Relationship: 1. 2. 3. 4. 5.	What are **stresses or family problems** since your child has been born (moves, deployments, marital conflicts, financial problems, etc.): 1. 2. 3.

FAMILY HISTORY:

Does anyone in the family have any of the following (check all that apply, past or present) :					
	Mother	Father	Sibs	Mother's side	Father's side
Intellectual Disability/Mental Retardation					
Learning Disabilities					
Attention problems; hyperactivity ("ADD/ADHD")					
Depression					
Anxiety Disorders					
Manic Depression/Bipolar Disorder					
Schizophrenia					
Heart problems/Sudden death from heart problems/heart rhythm problems/high blood pressure					
Emotional or behavioral disturbance					
Autism, PDD, Asperger Syndrome					
Birth defects, genetic syndromes					
Cerebral palsy					
Visual impairment (apart from just glasses for distance or reading)					
Hearing problems/hearing loss					
Other (Describe)					
PLEASE CHECK THIS ROW IF NONE OF THE ABOVE					

Is there anything else you would like to make sure we know about your child?

Thank you for your time!

-The Collaborative Motor Clinic Team

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