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: _____ Your name:_____
Child's Date of Birth:_____ Today's Date:_____
Child's PCM:_____ Phone Number:_____
Child's School or School District:_____
Email we may use to contact you:
_____

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 evaluations
- □ Occupational, Physical, and Speech Therapy Evaluations
- □ School Testing
- □ Individual and Family Service Plans
- □ Individualized Education Plans (the current one as well as the ones that show all of the testing that has been done, often referred to as "eligibility")
- □ Medical Evaluations

REASONS FOR EVALUATION

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

When did you first notice these problems?

What are your goals for today's visit?

Regarding **SOCIAL SKILLS**, does your child:

	Yes	No	Comments:
Want to share with you when he/she enjoys something?			
Have back and forth conversations about all sorts of topics?			
Understand and care about other peoples' feelings?			
Make eye contact when appropriate?			
Seem to understand facial expressions?			
Use facial expressions to communicate feelings?			
Use and understand gestures in communication?			
Know how to interact with children his/her age?			
Enjoy playing with others vs. alone?			
Make and keep friends easily?			
Engage in imaginative pretend play?			

Regarding **BEHAVIOR**, does your child:

	Yes	No	Comments:
Have any repetitive motor movements (flapping, spinning, jerking)?			
Play repetitively with toys (lining up, spinning, flipping)			
Often repeat back what you have just said/asked rather than answering a question?			
Often repeat word for word dialogue from TV/ movies or something you have said in the past?			
Insist on sameness in routine?			
Have trouble switching activities?			
Have rituals that have to be done a particular way?			
Have a variety of interests that are typical for age?			
Have any obsessions or particularly intense interests?			

	Yes	No	Comments:
Seem hyperactive, inattentive, or impulsive compared to peers?			
Seem unusually oppositional or argumentative?			
Hurt him/her?			
Hurt other people?			
Worry a lot (about what?)			

Have unusual responses to sensations?

	Under-reacts	Over-reacts	Average
Texture			
Touch			
Noises			
Lights			
Tastes			
Smells			
Pain			
Other			

How often does your child have tantrums/meltdowns/outbursts?

- ☐ Daily
- ☐ Many times daily
- ☐ Weekly
- ☐ Rarely

What are the triggers?

How long do they last?

DEVELOPMENTAL HISTORY

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			

These questions are about ***how*** your child is and has been most of his/her life.

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

CURRENT ABILITIES/FUNCTIONING

What does your child do well? What do you love about your child?

What do you and your child enjoy doing together?

What chores or jobs does your child do at home?

If you had to guess, what age child does your child most act like? _____

How would you rate your child's overall intelligence compared with others the same age?

- □ Below Average
- □ Average
- □ Above Average

Motor Skills: Are you concerned about your child's movement?: □ Yes □ No

Please check specific concerns:

- □ Walking
- □ Throwing/Catching
- □ Running/Jumping
- □ Balance/Coordination
- □ Other:

Language: Are you concerned about your child's language?: □ Yes □ No

Please check specific concerns:

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

Fine motor and adaptive skills: Are you concerned about your child's ability to take care of him/herself and use his/her hands?: □ Yes □ No

Please check specific concerns:

- □ Tying shoes
- □ Dressing
- □ Bathing/ self-hygiene
- □ Other:

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

Please check specific concerns:

- □ Reading
- □ Spelling
- □ Math
- □ Completing homework
- □ Study skills
- □ Organizational skills
- □ Failing grades
- □ Trouble staying on task or paying attention
- □ Expulsion/suspension

Do you or your child's teachers have any concerns about your child's behavior or social skills at school? □ Yes □ No

What is being done to work on learning, social, and behavior problems?

SCHOOL/THERAPY/SERVICES HISTORY

Is your child registered in the Exceptional Family Member Program (EFMP)? □ Yes □ No

	OT	PT	Speech	Other
Ages received through early intervention				
Ages received in school				
Ages received privately				
Current providers				

Check if there is a current:

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

Has your child had psycho-educational testing (IQ, achievement tests)? □ Yes □ No
If yes, when and by whom? _____

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 childlike 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.

Equipment

Does your child use any specialized equipment?: □ Yes □ No

Please specify:

- □ Wheelchair
- □ Orthotics
- □ Stander
- □ Communication device
- □ Other

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	**Father's**
Name:_____ Date of Birth:_____ Education Level:_____ Occupation:_____ Marital Status:_____	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 Neurodevelopmental Pediatrics Team.