Atrius Health

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DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS
PARENT QUESTIONNAIRE

Date: _____

Child's Name: _____

Child's Date of Birth (month/day/year): _____/_____/_____

Your Name: _____

Your relationship to child: _____

What do you think are the greatest strengths of your child?

_____

_____

What are your priorities for this evaluation?

_____

_____

Whose idea was it that your child be evaluated? _____

Please list any previous diagnoses given to your child for these issues:

_____

_____

PREVIOUS MEDICAL HISTORY

PREGNANCY AND DELIVERY (IF CHILD WAS ADOPTED, PLEASE PROVIDE WHAT INFORMATION IS KNOWN)

Did the child's mother have pregnancies prior to delivery of this child? _____ YES_____ NO

# of prior pregnancies:_____ # of prior miscarriages/stillbirths: _____

Were reproductive technologies used in this pregnancy?___YES ___NO If yes, please describe.

_____

Were there any illnesses in the mother during pregnancy?___YES ___NO If yes, please describe.

_____

How much did this child weigh at birth? _____ pounds ____ ounces or _____ kilograms

Length of pregnancy: _____ months or ____ weeks

Please describe any complications of labor or delivery? Include any medical complications for your child right after delivery, including any stay in the NICU .

_____

Was your child born by cesarean section? _____ YES _____ NO

HEALTH

Please describe any current medical problems your child has:

_____

_____

Is your child ***currently*** taking medications, vitamins, or supplements? ____ No ____ Yes

If yes, please list:

Type:	**Dose (if known):**	**Reason:**

In the ***past***, has your child taken any medications, vitamin, or supplement for over one month? _____ No ____ Yes

If yes, please list:

Type:	**Dose (if known):**	**Reason:**

Has your child had any of the following evaluations?

Test	**Yes**	**No**	**Date(s)**	**Results**
CT or MRI of brain				

EEG				
Genetic testing				
Other (specify)				

The following is a list of symptoms or medical problems this child might have had. Please check "yes" or "no" for each problem listed. If yes, please write in the column the age(s) when the child had the problem; include frequency. For example: Ear infections, 2-4 years of age, at least 6 infections.

	No	**Yes**	**Age(s)**
Surgeries (please specify)			
Hospitalizations (please specify)			
Colic (please specify):			
Frequent ear infection(s) If yes, about how many?__			
Meningitis/Encephalitis			
Seizures or convulsions			
Got sick after an immunization/shot			
Asthma or other lung problems (please specify):			
Endocrine disorder (such as diabetes, thyroid dysfunction) Please specify:			
Slow weight gain			
Trouble with hearing			
Trouble with vision			
Allergies (respiratory)			
Food allergies (please specify):			
Rashes or skin problems			
Special diet (specify type):			
Constipation			
Diarrhea (not associated with acute illness)			
Vomiting (not associated with acute illness)			
Lead poisoning (note highest level):			
Other poisoning or overdose			
History of syncope, fainting or palpitations			
Heart disease (please specify):			
Anemia			
Sickle cell disease or other blood disease			
Kidney or urinary problems			
Neurological disorder (such as Tourette's, epilepsy) Please specify:			
Psychiatric disorder (such as bipolar disorder, anxiety) Please specify:			
Physical deformity or handicap (please specify)			
Head injury/other injury (please specify)			
Other, please specify:			

DEVELOPMENTAL HISTORY

PLEASE LIST ANY KNOWN DELAYS IN MILESTONES, INCLUDING LANGUAGE AND MOTOR SKILLS

_____

_____

LANGUAGE DEVELOPMENT

How does your child communicate most of the time now? (check all that apply)

____ Babbling
____ Single words
____ Short phrases
____ Full sentences
____ Gestures
____ Repeats phrases from books or video
____ Other (please specify):

Has your child ever lost any language skills that they once had? _____ YES _____ NO
If yes, please describe: _____

_____

On average, how many hours per day does the child watch TV? _____

Use handheld electronic devices, computers, or video games? _____ hours per day

Do homework? _____ hours per day

What are your child's favorite toys, activities, or games? Does your child have any special interests?

_____

_____

Does your child have friends? If so, what are their approximate ages?

_____

CHILDCARE AND SCHOOL HISTORY

Type of school/program	Name, City	Dates of Attendance	Number of students, teachers, aides in classroom
Early Intervention Ages 0-3			
Preschool Ages 3-5			
Elementary School Kindergarten-5th gr			

Middle School 6th grade-8th grade			
High School 9th grade-12th grade			

Has the child ever repeated a grade? ____ YES ____ NO If yes, which grade(s): _____

Current grade in school: _____

Please list the services your child is receiving **in school currently**:

Please list the services your child is receiving **outside of school currently:**

FAMILY

Below is a list of problems that sometimes are present in families. Please check the appropriate column if there are any members of the child's family with this problem.

Family History	Child's Mother	Child's Father	Child's brother(s)	Child's sister(s)	Other (specify)
Significant medical illness					
Hyperactive or ADHD as a child					
A family history of either cardiomyopathy or sudden death < age 40					
Learning problems (please specify type)					
Kept back in school					
Speech/communication problems					
Behavior problems					
Depression					
Schizophrenia					
Anxiety					
Bipolar Disorder (Manic Depressive Illness)					
Obsessive Compulsive Disorder					
Seizure Disorder/Epilepsy					
Intellectual Disability (previously known as mental retardation)					
Autism/PDD/Autism Spectrum					

Disorder/Asperger's Syndrome					
Drinking problem or drug abuse					
Criminal or legal problems					
Other (specify)					

Mother's present age: _____ School level completed: _____

Present occupation: _____ General health: _____

Father's present age: _____ School level completed: _____

Present occupation _____ General health: _____

Please list all adults living in home and relationship to child: _____

Are this child's parents…. _____ married _____ separated _____ divorced _____ other?

Please list brothers/sisters living in the same household as this child and their ages:

_____

Who has legal custody of this child? _____

Was this child ever placed in foster care in the past? _____ YES _____ NO

Has this child ever endured any stressful experience? Please describe:

_____

_____

What is the principal language spoken at home? _____

Please indicate other languages spoken at home: _____