CHILDREN'S HEALTH

ASSESS
CMC86011-001NS Rev. 10/2021

# Developmental Behavioral Pediatrics Clinic Intake Questionnaire

**Place a patient label on all sheets**

Location: _____

Patient Name: _____

DOB: _____

Medical Record Number: _____

CSN: _____

Please fill out this form as completely as possible. This document will be reviewed prior to scheduling an appointment to determine if our clinic is the appropriate place for your child. By completing this questionnaire, you will be helping us to better understand your questions and concerns which are affecting your child and your family.

Fax the completed form to (214) 867-5461, attention to Developmental Behavioral Pediatrics (DBP) Clinic. If you have any questions, please call (214) 456- 5558.

Today's Date: _____ Name of Person Completing this form: _____

**Child Information:**

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Primary Phone: _____

Language spoken by the child: _____ Other languages spoken in the home: _____

Will you need a translator? ☐ Yes ☐ No
Which language should be spoken by the translator? _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race: ☐ American Indian or Alaska Native ☐ Asian, Asian-American or Pacific Islander
☐ Black or African American ☐ White ☐ Other

**Parent Guardian Information**

Mother / Guardian Full Name: _____ Marital Status: _____

Primary Phone: _____ Alternate Phone: _____

Email: _____

Father / Guardian Full Name: _____ Marital Status: _____

Primary Phone: _____ Alternate Phone: _____

Email: _____

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Who does the child live with? _____

Is this the legal guardian? ☐ Yes ☐ No Relationship to child: _____

**Referral History (Please be SPECIFIC):**

1. Who referred your child to this clinic? _____

2. Why were you referred to this clinic? _____

Please check the following reasons you are interested in an evaluation:

- ☐ Evaluate my child's attention and / or hyperactivity problems
- ☐ Evaluate my child's learning problems
- ☐ Evaluate my child's developmental delays (language skills, motor skills, social skills)
- ☐ Evaluate to determine if my child has an autism spectrum disorder
- ☐ Evaluate for anxiety
- ☐ General behavior concerns
- ☐ Medication consultation
- ☐ For a second opinion of my child's diagnosis, which is: _____

3. In the space below, please list your main concerns that you have for your child.

4. When did these problems begin? _____

5. What seems to help the problems? _____

6. What seems to make the problems worse? _____

7. Has your child received an evaluation or treatment for these problems before? ☐ Yes ☐ No

8. A. If yes, when and with whom? **Please provide a copy of any prior evaluations including any school evaluations.**

B. What is your child's diagnosis: _____

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9. Does your child's school have any concerns about your child's behavior? ☐ Yes ☐ No
If yes, please explain. (i.e., What are the concerns, when did these concerns begin.)

_____

_____

10. What do you hope to learn or gain from this visit? _____

_____

_____

**Family History**

**Mother's Name:** _____ Age: _____

Highest level of education completed:

☐ Grade school (grades 1-8) ☐ Some college
☐ High school, but didn't graduate ☐ College graduate
☐ High school, completed ☐ Post graduate level
☐ Training after high school, other than college

Occupation: _____
Place of employment: _____

**Father's Name:** _____ Age: _____

Highest level of education completed:

☐ Grade school (grades 1-8) ☐ Some college
☐ High school, but didn't graduate ☐ College graduate
☐ High school, completed ☐ Post graduate level
☐ Training after high school, other than college

Occupation: _____
Place of employment: _____

**Step-Parent's Name:** _____ Age: _____

Highest level of education completed:

☐ Grade school (grades 1-8) ☐ Some college
☐ High school, but didn't graduate ☐ College graduate
☐ High school, completed ☐ Post graduate level
☐ Training after high school, other than college

Occupation: _____
Place of employment: _____

**Step-Parent's Name:** _____ Age: _____

Highest level of education completed:

☐ Grade school (grades 1-8) ☐ Some college
☐ High school, but didn't graduate ☐ College graduate
☐ High school, completed ☐ Post graduate level
☐ Training after high school, other than college

Occupation: _____
Place of employment: _____

Parents are:

| | | | |
|---|---|---|---|
| Married | ☐ Yes | ☐ No | Date: _____ |
| Separated | ☐ Yes | ☐ No | Date: _____ |
| Divorced | ☐ Yes | ☐ No | Date: _____ |
| Unmarried | ☐ Yes | ☐ No | Date: _____ |
| Widowed | ☐ Yes | ☐ No | Date: _____ |

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If parents are divorced, who has legal custody? ☐ Mother ☐ Father ☐ Joint ☐ Other

If other, please specify: _____

- If parents are separated or divorced is there any disagreement regarding whether the child should receive clinical services through our department? ☐ Yes ☐ No
- If parents are separated or divorced is there a court ordered parenting plan or divorce decree that outlines parental rights related to the child's medical care? ☐ Yes ☐ No
- Are you hoping to use this evaluation in any legal proceedings? ☐ Yes ☐ No
- ***Please provide documentation regarding custody, we may not be able to evaluate your child unless this has been received.***
- If parents are divorced or separated, how often does the child visit the parent that he or she does not live with?

_____

_____

- Is this child a foster child? ☐ Yes ☐ No
- Is this child adopted? ☐ Yes ☐ No

If yes, please give as much information regarding biological parent(s) as you can: _____

_____

_____

- If a foster child or adopted child, how long has the child been in your home? _____
- If a foster child or adopted child, is this child aware that they are a foster child or adopted? ☐ Yes ☐ No

Who is living in the home at this time? (Please include everyone).

| Name | Age | Relationship to Child |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Family members living outside of the home. (For example, a biological parent, brothers or sisters).

| Name | Age | Relationship to Child |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

How many times has the child moved during the past 3 years? _____

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- During the past 12 months, has your family experienced any of the following situations:

| | | | Who (relationship to child) |
|---|---|---|---|
| Death of a family member | ☐ Yes | ☐ No | |
| Serious illness | ☐ Yes | ☐ No | |
| Unemployment | ☐ Yes | ☐ No | |
| Marital problems | ☐ Yes | ☐ No | |
| Psychiatric problems | ☐ Yes | ☐ No | |
| Alcohol / drug problems | ☐ Yes | ☐ No | |
| Legal problems | ☐ Yes | ☐ No | |

- Has anyone in the child's family experienced the following:

| | | | Who (relationship to child) |
|---|---|---|---|
| Speech or language problems | ☐ Yes | ☐ No | |
| Held back in school | ☐ Yes | ☐ No | |
| Intellectual disability | ☐ Yes | ☐ No | |
| ADHD (Attention Deficit Hyperactivity Disorder) | ☐ Yes | ☐ No | |
| Autism | ☐ Yes | ☐ No | |
| Learning disabilities | ☐ Yes | ☐ No | |
| Genetic disorder | ☐ Yes | ☐ No | |
| Suicide or attempted suicide | ☐ Yes | ☐ No | |
| Depression | ☐ Yes | ☐ No | |
| Anxiety | ☐ Yes | ☐ No | |
| Diagnosed with manic-depression | ☐ Yes | ☐ No | |
| Seizures / epilepsy | ☐ Yes | ☐ No | |
| Neurological disease / disorder | ☐ Yes | ☐ No | |

- Is there anyone in the family who is left-handed or ambidextrous (mixed-handed), please list relationship to the patient:

1. _____ 3. _____
2. _____ 4. _____

**Pregnancy and Birth History:**

**A. Pregnancy and Delivery - this section is to be completed by the child's mother if possible.**

Length of pregnancy (how many weeks / months?) _____
Did mother attend regular prenatal care? ☐ Yes ☐ No
Mother's age when child was born: _____
Child's birth weight: _____
Delivery was by: ☐ vaginal birth ☐ Cesarean (C-section)
Were forceps used? ☐ Yes ☐ No
Was delivery difficult? ☐ Yes ☐ No
Was it a breech birth? ☐ Yes ☐ No
Length of labor _____
Problems with delivery ☐ Yes ☐ No
(If yes, please describe; e.g., emergency cesarean section, slow heart rate, fever, cord around neck, etc.)

_____

_____

What were the Apgar scores @ 1 minute _____ 5 minutes _____ 10 minutes _____

Location: _____

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**Developmental Behavioral Pediatrics Clinic Intake Questionnaire**

**B. Biological Mother's Health During Pregnancy**

Did the child's mother experience any of the following during pregnancy?

| | | |
|---|---|---|
| Bleeding | ☐ Yes | ☐ No |
| Gained 30 or more pounds | ☐ Yes | ☐ No |
| Had toxemia or high blood pressure | ☐ Yes | ☐ No |
| Had to take prescription medications | ☐ Yes | ☐ No |

(If yes, name(s) of medication) _____

_____

| | | |
|---|---|---|
| Serious injury or illness | ☐ Yes | ☐ No |
| Alcohol use | ☐ Yes | ☐ No |
| Drug use | ☐ Yes | ☐ No |
| Smoked cigarettes | ☐ Yes | ☐ No |
| Had fever, rash, infection or other illness | ☐ Yes | ☐ No |
| Had X-Rays | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Other | ☐ Yes | ☐ No |

_____

C. **Infant's Health at Delivery**

| | | |
|---|---|---|
| Trouble breathing | ☐ Yes | ☐ No |
| Turned blue (cyanosis) | ☐ Yes | ☐ No |
| Needed oxygen | ☐ Yes | ☐ No |
| Turned yellow (jaundice) | ☐ Yes | ☐ No |
| Required light therapy | ☐ Yes | ☐ No |
| Hospitalized after birth more than 7 days | ☐ Yes | ☐ No |

Why? _____

| | | |
|---|---|---|
| Birth defects | ☐ Yes | ☐ No |
| Jittery | ☐ Yes | ☐ No |
| Did your child require any special care shortly after birth | ☐ Yes | ☐ No |

(If yes, please describe; e.g., blood transfusions, oxygen, incubator, medications, etc.)

_____

_____

D. **Health During the Neonatal Period (first month):**

In the first month of life did your child experience:

| | | |
|---|---|---|
| Infections | ☐ Yes | ☐ No |
| Gagging, choking or vomiting often | ☐ Yes | ☐ No |
| Difficulty sucking or feeding | ☐ Yes | ☐ No |

In the box below, please explain any other important information about your child's birth:

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**Health / Medical History:**

Who is you child's primary care doctor? _____

Please list the name, specialty, hospital or program affiliation, and address of any other physicians currently providing medical care to your child.

| Physician's Name | Specialty | Hospital / Program Affiliation | Address (if available) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

| List of current medical diagnoses | |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Has your child ever had surgery? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No

Please include any psychiatric hospitalization.

| Date | Reason | Length of Stay |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has your child had any of the following medical conditions? **Check if yes.**

| | | | | | |
|---|---|---|---|---|---|
| Speech / language problems | | Frequent abdominal pain | | Bowel Problems | |
| Eye or vision problems | | Frequent or severe headaches | | Serious illness after immunizations | |
| Hearing difficulties | | Chronic ear infections | | Heart or blood pressure problems | |
| Fine Motor problems | | Pneumonia | | Asthma | |
| Gross motor problems | | Meningitis | | Seizures / Neurologic Problems | |
| Appetite or feeding problems | | Kidney problems | | Head injury or loss of consciousness | |
| Food allergies | | Broken bones | | Motor / vocal tics | |
| Other allergies | | Bladder Problems | | Sleeping problems | |

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**Behavioral Pediatrics Clinic**
**Pediatric History Questionnaire**
**Developmental**

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CSN: _____

**If you checked yes to any of the above, please explain below:**

Is your child taking any medications on a regular basis? ☐ Yes ☒ No

| Medications | Condition the medication is treating | Medications | Condition the medication is treating |
|---|---|---|---|
| 1. | | 1. | |
| 2. | | 2. | |
| 3. | | 3. | |
| 4. | | 4. | |
| 5. | | 5. | |

Has your child ever been seen by a psychologist, psychiatrist, or counselor?
If yes, at what age and for how long? _____
What was the diagnosis? _____

Please indicate whether your child has ever been diagnosed with any of the following conditions:

| | | | | | | |
|---|---|---|---|---|---|---|
| ADD, AD / HD | ☐ Yes | ☐ No | Age at diagnosis | _____ | By whom | _____ |
| Learning disability | ☐ Yes | ☐ No | Age at diagnosis | _____ | By whom | _____ |
| Depression | ☐ Yes | ☐ No | Age at diagnosis | _____ | By whom | _____ |
| Anxiety | ☐ Yes | ☐ No | Age at diagnosis | _____ | By whom | _____ |
| Autism / Asperger's | ☐ Yes | ☐ No | Age at diagnosis | _____ | By whom | _____ |
| Other Please specify: _____ | | | Age at diagnosis | _____ | By whom | _____ |

Location: _____

Patient Name: _____

DOB: _____

Medical Record Number: _____

CSN: _____

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**Behavioral Pediatrics Clinic**
**Pediatric History Questionnaire**
**Developmental**

**Developmental History:**

- At what age did your child:

| | | | |
|---|---|---|---|
| Sit without help? | _____ | Say single words meaningfully? | _____ |
| Crawl? | _____ | Combine 2 or more words? | _____ |
| Pull to a stand? | _____ | Combine 3 or more words? | _____ |
| Stand without help? | _____ | Use full sentences? | _____ |
| Cruise (walk holding on) | _____ | Use gestures to communicate? | _____ |
| Walking independently? | _____ | Use gestures with words? | _____ |
| Walk up / downstairs? | _____ | Show a hand preference? | _____ |
| | | Which hand? | _____ |

**If your child is 5 years of age and younger:**

- About how many words are in your child's vocabulary? _____
- How much of what your child hears, does he / she understand? _____
- How many steps in an instruction can your child follow? _____
- How much of what your child says, can *you* understand? _____
- How much of what your child says, can *others* understand? _____

- Is your child toilet trained? ☐ Yes ☐ No
  If yes, what age? _____
- Does your child have toileting accidents *during the day?* ☐ Yes ☐ No
  If yes, how often? _____
- Does your child have any toileting accidents *during the night?* ☐ Yes ☐ No
  If yes, how often? _____
- Does your child have sleeping difficulties? ☐ Yes ☐ No
  (i.e. Difficulty going to bed, falling and / or staying asleep?)
  If yes, please describe: _____
- Does your child have any eating difficulties? ☐ Yes ☐ No
  If yes, please describe: _____
- What toys or activities does your child seem to enjoy? _____
  _____
  If yes, how often: _____

**Educational History:**

- Did your child attend preschool? ☐ Yes ☐ No
  Age patient started kindergarten: _____ School: _____
  Problems reported in Preschool: _____
- Did your child attend special needs preschool? ☐ Yes ☐ No
  Age patient started kindergarten: _____ School: _____

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**Pediatric History Questionnaire**
**Developmental**

- Age patient started Kindergarten : _____ School: _____
- Has your child ever repeated a grade? ☐ Yes ☐ No
  If yes, what grades? _____
- Has your child had a frequent change of schools? ☐ Yes ☐ No
  If yes, how many schools has he / she attended? _____
- Current grade placement: _____
- Name of current school: _____
- Has your child received or is currently receiving any of the following services:

| | Ages or Grades |
|---|---|
| Speech / Language therapy | _____ |
| Physical Therapy | _____ |
| Occupational Therapy | _____ |
| Learning Disabilities Tutoring | _____ |
| Counseling | _____ |
| Others, please describe: | _____ |

- Has your child ever been placed in any of the following special educational programs? Check if yes.

☐ Developmental Preschool
☐ Emotional Handicapped
☐ Intellectual Disability
☐ Learning Disabilities Resource Room
☐ Multiple Handicapped
☐ Hearing Impaired
☐ Visually Impaired
☐ Other (specify): _____

**If your child is 5 years of age and older and in school,** please indicate how your child is doing in each of these areas:

| | Serious Problem | Below Average | Average | Excellent |
|---|---|---|---|---|
| Reading | | | | |
| Spelling | | | | |
| Math | | | | |
| Writing | | | | |
| Behavior | | | | |
| Athletics | | | | |
| Attendance | | | | |
| Turning in assignments | | | | |
| Social or friends | | | | |

If appropriate, is your child involved in any vocational education? ☐ Yes ☐ No ☐ Not Applicable

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What do you enjoy most about raising your child?

What do you find the most difficult about raising your child?

Please add any additional information that you believe will help us to better understand your child.

**Thank you for taking the time to complete this form. Please send this back along with any additional paperwork and reports, including previous evaluations (psychological / neuropsychological, IEP, 504, ARD paperwork, etc.).**