**Developmental-Behavioral Pediatrics Questionnaire for New Patients**

Date: \_\_\_\_\_\_\_\_\_\_ Name of person completing questionnaire:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **IDENTIFYING INFORMATION:** | |
| **Information** |  |
| Child Name |  |
| Child Birthdate |  |
| Child Home Address |  |
| Parent 1/Guardian Name |  |
| Parent 2/Guardian Name |  |
| Primary Doctor Name |  |
| Referring Doctor Name |  |
| School Name/Program |  |
| Teacher & Grade |  |
| School Contact |  |

**CONCERNS:**

What is your main concern?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How old was the child when you first became concerned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How can we help you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What other concerns do you have about the child’s behavior or development?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the child previously been evaluated for this concern or related concerns regarding development, behavior, or education? ☐ Yes / ☐ No

|  |  |  |  |
| --- | --- | --- | --- |
| **Who did the evaluation?** | **Check Box** | **Date** | **What did they tell you?** |
| Early Start or Regional Center |  |  |  |
| School or IEP team |  |  |  |
| Psychologist |  |  |  |
| Education Specialist |  |  |  |
| Therapist |  |  |  |
| Other: |  |  |  |
| Other: |  |  |  |

Did the child have any delays in early development? ☐ Yes / ☐ No

Did the child ever show regression or lose skills they previously had? ☐ Yes / ☐ No

**How old was the child when the following skills appeared?**

|  |  |  |
| --- | --- | --- |
| **Skill** | **Age** | **Comments** |
| Sitting without help |  |  |
| Walking |  |  |
| Saying first words |  |  |
| Making 2-word phrases |  |  |
| Using toilet in daytime |  |  |
| Showing pretend or imaginary play |  |  |
| Learning letters/numbers |  |  |
| Learning to read |  |  |

**ADAPTIVE FUNCTIONING:**

What does the child like to do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the child’s strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What new skill(s) has the child learned in the past year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What skill(s) has the child struggled to learn in the past year, despite attempts at teaching? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please tell us how this child compares to other children of the same age? Check the last column if you’re not sure or the child is too young for o that skill.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Developmental Area** | **Far Behind** | **Slightly**  **Behind** | **Same as others** | **Slightly Ahead** | **Far Ahead** | **Not sure/ too young** |
| Learning |  |  |  |  |  |  |
| Reading |  |  |  |  |  |  |
| Writing |  |  |  |  |  |  |
| Math |  |  |  |  |  |  |
| Science |  |  |  |  |  |  |
| Social Studies |  |  |  |  |  |  |
| Art |  |  |  |  |  |  |
| Music |  |  |  |  |  |  |
| Handling tasks & demands |  |  |  |  |  |  |
| Communication or talking |  |  |  |  |  |  |
| Understanding direction |  |  |  |  |  |  |
| Mobility or walking |  |  |  |  |  |  |
| Athletics or sports |  |  |  |  |  |  |
| Ability to use hands &  fingers |  |  |  |  |  |  |
| Taking care of self, such as dressing, bathing, etc. |  |  |  |  |  |  |
| Relating to close family |  |  |  |  |  |  |
| Relating to adults |  |  |  |  |  |  |
| Relating to other children |  |  |  |  |  |  |

**Do you have concerns in any of the following areas?**

|  |  |  |
| --- | --- | --- |
| **Area** |  | **Describe** |
| Eating, feeding, nutrition, including limited diet | ☐ Yes / ☐ No |  |
| Toileting, including urine or stool accidents | ☐ Yes / ☐ No |  |
| Sleeping, including difficulty falling asleep or snoring | ☐ Yes / ☐ No |  |
| Intense or unusual interests | ☐ Yes / ☐ No |  |
| Repetitive behaviors | ☐ Yes / ☐ No |  |
| Other: | ☐ Yes / ☐ No |  |
| Other: | ☐ Yes / ☐ No |  |

**What services and supports is the child getting now?**

|  |  |  |
| --- | --- | --- |
| **Service** | **Age began** | **Provider and comments** |
| Day Care or Preschool |  |  |
| Early Intervention, IFSP |  |  |
| Speech-Language Therapy |  |  |
| Occupational Therapy |  |  |
| Physical Therapy |  |  |
| Applied Behavioral Analysis, ABA |  |  |
| General Education |  |  |
| Special Education, IEP |  |  |
| Mental Health Services |  |  |
| Regional Center (over age 3 yrs) |  |  |
| Other: |  |  |

**PAST BIRTH AND MEDICAL HISTORY:**

Was child born near the due date (at term?) ☐ Yes / ☐ No If no, how many weeks gestation at birth? \_\_\_\_\_ How much did child weigh at birth? \_\_\_\_\_\_\_\_\_\_ How old was child’s mother when the child was born? \_\_\_\_How many times has mother been pregnant? \_\_\_\_What birth order was this child? \_\_\_\_\_ Is this child a twin or triplet? ☐ Yes / ☐ No Name of twin (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems during pregnancy? ☐ Yes / ☐ No If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems during labor? ☐ Yes / ☐ No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems at delivery? ☐ Yes / ☐ No If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the child treated in the intensive care? ☐ Yes / ☐ No If yes, where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Has child ever been** | **Date** | **Reason & results** |
| To the Emergency Room |  |  |
| Hospitalized |  |  |
| Diagnosed with a chronic medical condition |  |  |
| In a serious accident |  |  |
| In Surgery |  |  |
| **Has the child been evaluated for** |  | **Date of evaluation?** |
| Hearing | ☐ Yes / ☐ No |  |
| Vision | ☐ Yes / ☐ No |  |
| Genetic conditions | ☐ Yes / ☐ No |  |
| Neurological conditions, such as seizures | ☐ Yes / ☐ No |  |
| Other: | ☐ Yes / ☐ No |  |

**MEDICATIONS:**

|  |
| --- |
| List all medications that the child is currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List any complementary or alternative treatments the child is using:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ALLERGIES:**

Does the child have allergies? ☐ Yes / ☐ No If Yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

Is the child adopted? ☐ Yes / ☐ No Are the parents divorced or separated? ☐ Yes/ ☐ No

Has your family ever had a significant stress, trauma, or loss that you think may have impacted the

child? ☐ Yes / ☐ No Please briefly describe what, when, and is it over or ongoing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any details about your family you would like to share?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is in your family?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Family Member** | **Lives in home** | **Age** | **Name** | **Education** | **Occupation** |
| Parent 1 | ☐ Yes / ☐ No |  |  |  |  |
| Parent 2 | ☐ Yes / ☐ No |  |  |  |  |
| Sibling 1 | ☐ Yes / ☐ No |  |  |  |  |
| Sibling 2 | ☐ Yes / ☐ No |  |  |  |  |
| Sibling 3 | ☐ Yes / ☐ No |  |  |  |  |
| Other: | ☐ Yes / ☐ No |  |  |  |  |
| Other: | ☐ Yes / ☐ No |  |  |  |  |
| Other: | ☐ Yes / ☐ No |  |  |  |  |
| Other: | ☐ Yes / ☐ No |  |  |  |  |

**FAMILY MEDICAL HISTORY:**

**Does anyone in the family have (or had) any of the following conditions?**

|  |  |  |
| --- | --- | --- |
| **Condition** |  | **Which family member?** |
| Developmental delays | ☐ Yes / ☐ No |  |
| Delays in language/talked at late age | ☐ Yes / ☐ No |  |
| Learning problems, such as dyslexia or poor reading | ☐ Yes / ☐ No |  |
| Intellectual disability/Global delays | ☐ Yes / ☐ No |  |
| Autism | ☐ Yes / ☐ No |  |
| Attention deficit (ADHD) | ☐ Yes / ☐ No |  |
| Depression or anxiety, including suicide | ☐ Yes / ☐ No |  |
| Schizophrenia or bipolar disorder | ☐ Yes / ☐ No |  |
| Tics or Tourette syndrome | ☐ Yes / ☐ No |  |
| Genetic disorder or birth defect | ☐ Yes / ☐ No |  |
| Seizure or epilepsy | ☐ Yes / ☐ No |  |
| Addiction or alcoholism | ☐ Yes / ☐ No |  |
| Cardiac disease, including sudden death | ☐ Yes / ☐ No |  |
| Other: | ☐ Yes / ☐ No |  |
| Other: | ☐ Yes / ☐ No |  |

**REVIEW OF SYMPTOMS**:

**Other than the information you have already provided, does the child have any other conditions?**

|  |  |  |
| --- | --- | --- |
| **Condition or body area or function** |  | **Describe** |
| General health, such as energy level, difficulty gaining weight, or overweight | ☐ Yes / ☐ No |  |
| Eyes or vision | ☐ Yes / ☐ No |  |
| Ears or hearing | ☐ Yes / ☐ No |  |
| Mouth or teeth | ☐ Yes / ☐ No |  |
| Breathing or respiration, including asthma | ☐ Yes / ☐ No |  |
| Heart or cardiovascular/circulation | ☐ Yes / ☐ No |  |
| Digestion/stooling or gastrointestinal, including recurrent vomiting | ☐ Yes / ☐ No |  |
| Elimination/urination/peeing or genitourinary | ☐ Yes / ☐ No |  |
| Muscles/bones or Musculoskeletal | ☐ Yes / ☐ No |  |
| Nerves/brain or Neurological, such as staring spells, shaking, or seizures | ☐ Yes / ☐ No |  |
| Skin, including eczema, birthmarks or rashes | ☐ Yes / ☐ No |  |
| Allergy or immunological | ☐ Yes / ☐ No |  |
| Endocrine or hormones | ☐ Yes / ☐ No |  |
| Blood or hematologic | ☐ Yes / ☐ No |  |
| Mental health or psychiatric | ☐ Yes / ☐ No |  |
| Behavior, including lying, stealing, setting fires, or cruelty to animals | ☐ Yes / ☐ No |  |

**ADDITIONAL INFORMATION:**

Is there anything else you would like us to know before the child’s visit?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank you for completing this form!

**Please return completed form by Mail or Fax to:**

**Stanford Children’s Referral Center**

4700 Bohannon Drive, Menlo Park, CA 94025

Office #: 800-995-5724

Fax #: 650-721-2884