Parent Questionnaire for New Patients

The attached questionnaire gives you a chance to tell us about your child. We want to know about your concerns and worries so that we can try to help. Knowing about things like your child's health, past experiences, and family history can help us help your child.

The questionnaire should be completed by the person who takes care of the child most of the time. There is no right or wrong answer. Answer each question to the best of your ability. If you do not know the answer, make notes of what you do know.

We need this form before we can schedule your child's appointment. It will be reviewed by staff at Developmental and Behavioral Pediatrics who will be involved in your child's care. When you talk with our intake team, please ask any questions you have while trying to complete these forms. Please also let us know about problems that were not covered on the forms.

If you have questions about this form or have difficulty filling it out, please call our intake coordinators at **(585) 275-2986**.

All information is kept strictly confidential.

Once you have completed this form, please send it to:

Intake Coordinator
Developmental Behavioral Peds @ E. River Road
601 Elmwood Avenue, Box 278877
Rochester, NY 14642

Fax: (585) 742-4217
DBPintake@URMC.rochester.edu

Child's name _____ Child's date of birth _____

Child's address _____ Date form completed _____

Child's medical insurance company _____ Policy Number

Persons Completing Form

Name	Relationship to child	Does the child live with you?	Phone numbers
	☐ Biologic parent ☐ Foster/adoptive parent ☐ Relative ☐ Guardian ☐ Other	☐ Yes ☐ No	(H) (C) (W)
	☐ Biologic parent ☐ Foster/adoptive parent ☐ Relative ☐ Guardian ☐ Other	☐ Yes ☐ No	(H) (C) (W)

Home Information

Main language spoken at home	☐ English ☐ Spanish ☐ American sign language ☐ Other:

Please list all adults and children who live at home with this child.

Name	Age	Relationship to child	Occupation or grade in school	Has this person ever been seen in Kirch/DBP?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are there any living arrangements (for example, shared custody or foster care), custody issues, parental disagreement about care, or orders of protection that we should be aware of?

What is the reason you would like your child seen in this program? What questions do you have?

Has your child ever been diagnosed by a doctor or psychologist with a developmental or behavioral disorder?

☐ Yes ☐ No ☐ Autism ☐ ADHD ☐ Cerebral palsy ☐ Anxiety disorder

Who made the diagnosis and when? ☐ Down syndrome ☐ Other:

_____

Has anyone (teacher, pediatrician, friend, relative) suggested your child be evaluated for a specific diagnosis?

☐ Yes ☐ No

What diagnosis?

Child Strengths

Tell us about the child's **strengths**. What is your child good at? What are his or her interests? What things are going well?

Parent/Guardian Concerns

What concerns do you have about your child right now?

Concern	
Large motor skills (sitting, walking, running, moving around)	☐
Small motor skills (using hands and fingers, writing, using utensils)	☐
Communication (using words/gestures/signs; expressing wants/needs, understanding others)	☐
Thinking, learning, and memory	☐
Social skills (making friends, playing with others, showing interest in others)	☐
Play skills (using toys, pretend playing)	☐
Self-care (feeding himself/herself, getting dressed/undressed, helping around the house)	☐
Short attention span	☐
Hyperactivity (constantly moving, restless, active)	☐
Anxiety (worrying, shy, fearful, problems separating from parents)	☐
Repetitive thoughts/behavior (does things over and over, gets "stuck")	☐
Repetitive motor mannerisms (rocks, flaps hands, walks on toes, paces)	☐
Mood swings/irritability (unpredictable changes between emotions)	☐
Tantrums	☐
Aggression (hits or bites others)	☐
Self-injury (bangs head, hits self, bites self)	☐
Sensory issues (over/under-sensitive to sounds, touch, smell)	☐
Sleep problems (trouble falling asleep, wakes frequently, still sleeps with adult)	☐
Safety problems (runs away, escapes from house, poor awareness of danger, climbs to high spots)	☐
Other behavior concerns	☐

Please make notes about any concerns selected above.

Health History

Are any of the following health concerns a problem for the child currently or were a past concern?

Concern	Never	Currently	In the past
Genetic disorder	☐	☐	☐
Head injury/brain problem (hydrocephalus, brain bleed)	☐	☐	☐
Seizures	☐	☐	☐
Headaches	☐	☐	☐
Tics, tremors, or unusual movements	☐	☐	☐
Eye or vision problem	☐	☐	☐
Ear or hearing problem	☐	☐	☐
Dental or tooth problem	☐	☐	☐
Heart problem	☐	☐	☐
Heart rhythm problems	☐	☐	☐
Breathing/lung problem, asthma	☐	☐	☐
GI problem: vomiting/reflux/stomach pain	☐	☐	☐
Diarrhea (loose, watery stools)	☐	☐	☐
Constipation (hard, painful stools)	☐	☐	☐
Feeding problem or use of a feeding tube	☐	☐	☐
Putting things in mouth that are not food	☐	☐	☐
Kidney/bladder/genital problems	☐	☐	☐
Bone, joint, or muscle problems	☐	☐	☐
Anemia or other blood problems	☐	☐	☐
Skin rashes	☐	☐	☐
Endocrine or hormone problems	☐	☐	☐
Allergies	☐	☐	☐
Health concern not listed above	☐	☐	☐

If you selected any of the boxes above, please describe…

Does your child use any adaptive equipment?

☐ Glasses ☐ Hearing aids ☐ Walker ☐ Wheelchair ☐ Communication device ☐ Other:

What medicines, vitamins, and nutrition supplements does your child take each day?

Medicine name or vitamin/supplement name and brand	**Dose (how many mg and how often)**	**Reason and who writes prescriptions**

Has your child taken medicines to treat chronic health or behavior problems *in the past*?

Medicine name	**Dose (how many mg and how often)**	**Reason**
Does your child eat a special diet or have any food restriction? Please describe.		

Has your child ever been admitted to the hospital overnight or had surgery?

Age	**Reason**

Has your child had blood drawn to test lead level?	☐ Yes ☐ No ☐ Unsure
If "Yes", was the lead level high?	☐ Yes ☐ No ☐ Unsure
Is your child up to date on immunizations?	☐ Yes ☐ No ☐ Unsure
Has your child had a hearing test?	☐ Yes ☐ No ☐ Unsure
If "Yes", at what age?	

Pregnancy and Birth History

The following questions are about the pregnancy ***with the child being evaluated***.

How many times has the mother been pregnant?	
How many children does the birth mother have?	
How many of those children are older than this child?	

Did the birth mother…

Lose any pregnancies (have a miscarriage)	☐ Yes ☐ No ☐ Unsure
Terminate any pregnancies due to a health problem/genetic condition of the baby?	☐ Yes ☐ No ☐ Unsure
Need treatment to become pregnant (fertility medicine, intrauterine insemination, IVF)?	☐ Yes ☐ No ☐ Unsure
Receive prenatal care?	☐ Yes ☐ No ☐ Unsure
Have any infections or fevers during the pregnancy?	☐ Yes ☐ No ☐ Unsure
Have high blood pressure during pregnancy?	☐ Yes ☐ No ☐ Unsure
Have diabetes during pregnancy?	☐ Yes ☐ No ☐ Unsure
Have any other complications during pregnancy?	☐ Yes ☐ No ☐ Unsure If "Yes", please describe:

What vitamins and medicines did the biological mother take during pregnancy?

Choose the one that best describes alcohol use *during* pregnancy…

☐ Unsure if mother used or not ☐ Mother used, but unsure of amount ☐ No use ☐ 1 drink or less per week
☐ 1 drink per day ☐ 2 or more drinks per day

** If unsure, it is very helpful to the evaluation to try to obtain birth records or talk to the birth mother or those who knew her during pregnancy to find out more information. **

During which trimesters did the mother drink alcohol?	☐ None ☐ Unsure ☐ 1st ☐ 2nd ☐ 3rd
What other substances were taken during pregnancy?	☐ Tobacco ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Pain Killers ☐ Meth ☐ Other:

Labor and Delivery

Birth mother's age at birth of child _____ Birth father's age at birth of child _____ Birth weight _____

Birth length _____ Birth head circumference _____

Was this child…	☐ Single birth ☐ One of twins ☐ One of triplets ☐ Other multiple
Was this child born by…	☐ Vaginal delivery ☐ Cesarean section
Were there any labor/delivery complications?	☐ Yes ☐ No If "Yes", please describe:
Was the baby born early?	☐ Yes ☐ No ☐ Unsure If "Yes", weeks early:
Was your child admitted to the Special Care Nursery or NICU (neonatal ICU)?	☐ Yes ☐ No ☐ Unsure If "Yes", please describe:
When discharged from the hospital, who did your child go home with?	☐ Biologic mother/parents ☐ Grandparents ☐ Other relative ☐ Foster parent ☐ Other

Developmental History

Please describe any concerns about your child's development between birth and age 3.
Please describe if your child has ever lost skills he/she once had (i.e., learned words then stopped talking).

Is your child…	Yes	No	Age learned
Walking without holding on?	☐	☐	
Using single words?	☐	☐	
Using phrases to talk?	☐	☐	
Toilet trained?	☐	☐	

Child Experiences and Social History

Has your child experienced any of the following?

Serious illness, surgery, or hospitalization?	☐ Yes ☐ No ☐ Unsure
Serious illness, surgery, or hospitalization of a close family member?	☐ Yes ☐ No ☐ Unsure
Death of someone close?	☐ Yes ☐ No ☐ Unsure
House fire, flood, storm, or other disaster?	☐ Yes ☐ No ☐ Unsure
Divorce of parents or caregivers?	☐ Yes ☐ No ☐ Unsure
Alcohol or drug abuse by a family member?	☐ Yes ☐ No ☐ Unsure
Seeing parents hitting/hurting each other?	☐ Yes ☐ No ☐ Unsure
Mental illness in a family member?	☐ Yes ☐ No ☐ Unsure
Seeing violence in the community (robbery, shooting, etc.)?	☐ Yes ☐ No ☐ Unsure
Neglect (adult caregiver not giving the child the care he/she needs)?	☐ Yes ☐ No ☐ Unsure
Physical abuse?	☐ Yes ☐ No ☐ Unsure
Sexual abuse?	☐ Yes ☐ No ☐ Unsure
Placement in foster care?	☐ Yes ☐ No ☐ Unsure
Change in primary caregiver?	☐ Yes ☐ No ☐ Unsure

For children in the care of a relative, adoptive or foster parent, or someone who is NOT the biologic parent…

How long has this child been in your care?	
Describe the circumstances that led to you caring for this child.	
If this child has been in the care of others who are not the biologic parents, please indicate when and who.	

Family History

Please indicate if someone in the child's biologic family has any of the following disorders.

ADHD	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Autism spectrum disorder	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Blindness or visual impairment in childhood	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Bipolar disorder	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Celiac disease	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Cerebral palsy	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Deafness present at birth or in childhood	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Depression	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Diabetes	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Heart rhythm problems, pacemaker, defibrillator	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Heart attack at young age (under age 40)	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Intellectual disability	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Learning disability	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Migraine headaches	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Miscarriages or loss of more than one pregnancy	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Schizophrenia	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Seizures	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Speech delay or disorder	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Sudden death	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Sudden infant death syndrome (SIDS), other death in infancy	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*

Tremor or other problem with moving muscles	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Other conditions not listed above	☐ Yes ☐ No ☐ Unsure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Relative on mother's side ☐ Relative on father's side *Relationship:*
Please describe…		

Current Education/School

Home school district	
School name	
Does the child have any of the following supports?	☐ AIS ☐ 504 plan ☐ IEP ☐ FBA ☐ BIP ☐ EI ☐ IFSP ☐ District-based services ☐ Unsure
Please select the educational services your child receives.	☐ Speech therapy ☐ Physical therapy ☐ Occupational therapy ☐ Special education teacher ☐ Small classroom ☐ DIR/floortime ☐ Vision therapy/services ☐ Social skills training ☐ ABA ☐ Counseling ☐ Learning center/resource room ☐ Other:

Home and Community Supports	**Name/address**	**Phone number**
Individual therapy/behavior intervention/counseling ***(A treatment summary from the child's therapist is VERY important to our evaluation; please include with the information you send us!)***		
OPWDD services/SPOA services/Bridges to Health		
Psychiatrist ***(A treatment summary from the child's psychiatrist is VERY important to our evaluation; please include with the information you send us!)***		

Please list any clubs, activities, or sports your child is involved with.

Consent for Evaluation

I request that my child (named above) be evaluated by Developmental and Behavioral Pediatrics at Golisano Children's Hospital. I understand that Developmental and Behavioral Pediatrics is a training facility and that trainees supervised by faculty may be utilized to administer some evaluations.

If there is joint custody, signatures are required from both parents.

_____ _____

Parent/Caregiver Signature *Date*

_____ _____

Parent/Caregiver Signature *Date*