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	
Primary Language	
Parent 1/Guardian Name/Phone Number	
Parent 2/Guardian Name/Phone Number	
Primary Doctor Name	
Referring Doctor Name	
School Name/Program	
Teacher & Grade	

CONCERNS:

What is your main concern?

_____

_____

How old was the child when you first became concerned?

_____

_____

How can we help you?

_____

_____

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

_____

_____

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

Who completed the evaluation?	Check Box	Date	What did they tell you?
Early Start or Regional Center			
School or IEP team			
Psychologist (School)			

Psychologist (Private)			
Education Specialist			
Therapist			
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?
_____
_____

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 & 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?
_____
_____

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?

_____

_____

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