MRN: _____

Brenner Children's Hospital
Developmental Behavioral Pediatrics Clinic Intake Form

PARENTS: *To help us provide the most useful subspecialty evaluation, we need more information about your child's problem(s) and about your family. Therefore, we ask that both parents fill out this questionnaire as completely as possible. Use separate sheets of paper if more space is required. This record will remain confidential in compliance with HIPAA regulations.*

CHILD'S NAME	CHILD'S BIRTH DATE	AGE	TODAY'S DATE

HOME ADDRESS	PHONE: Home_____ Cell_____
Form completed by (Name, relationship to patient):	E-MAIL:

PARENT/ LEGAL GUARDIAN'S NAME	OCCUPATION	AGE	CELL/WORK PHONE

OTHER PARENT/ LEGAL GUARDIAN'S NAME	OCCUPATION	AGE	CELL/ WORK PHONE

Please list the problem(s), question(s) or concern(s) you have for your child.

What is the issue?	When was this issue first noticed?
1.	1.
2.	2.
3.	3.

How do you think we may be able to help your child?

What specific event led you to request an evaluation at this time?

What do you think may have caused the problem(s)?

What have you already done for the problem(s) and with what results?

Has your child been treated for behavioral/ emotional/ developmental problems in the past? ☐Yes ☐ No
(If Yes, please complete a Release of Information at appt. so that we may obtain the treatment records)
Where? When? By Whom?

What types of treatment has your child had in the past? ☐Medications (please list):
☐None ☐Counseling (where):
☐Other (please list):

PRENATAL AND EARLY INFANCY HISTORY

List all pregnancies for patient's mother.

Date	What was the outcome? (full term, premature birth, or miscarriage)

Was this pregnancy planned? ☐ Yes ☐No

Any difficulty becoming pregnant? Month of pregnancy when prenatal care started?

Check any complications that occurred during this pregnancy:
□bleeding □high blood pressure □diabetes □trauma □Rh factor incompatibility □fever □rash □stresses
□hospitalization □seizures □sexually transmitted diseases □other:

Mother's health during pregnancy (check one): ☐good ☐fair ☐poor

Check any prenatal exposure(s) for this pregnancy?
□Alcohol □Smoking □Street drugs □Medications □Abuse of mother

Please list any medications that the mother used during the pregnancy:

Baby's movements in utero were ☐average ☐less active than expected ☐more active

Mother's age at time of delivery? Length of pregnancy?

Check any problems with this delivery:
□c-section □forceps □oxygen □breech □multiples □premature rupture of membranes □failure of labor to progress
□maternal fever □abnormal bleeding □ abnormalities noted at birth □maternal GBS □other:

Baby's APGAR scores: Birth Weight: Birth Length: Head Circumference:

Check any problems the baby had while in the hospital:
□taken care of in a NICU □needed oxygen for more than 4 hours □on ventilator □jaundice □seizures
□birth defects □blood transfusion □feeding problems □abnormal muscle tone □infections □meningitis
□hyaline membrane disease □bleeding in the brain □problems with low blood sugar □problems with growing
□abnormal head ultrasound or imaging □other:

In the first 6 months of life, did your baby have any of the following? (Check all that apply)
□excessively quiet/sleepy times □excessively hyperactive or irritable mood □colic □floppy muscle tone
□poor head control □didn't like to be held/cuddled □poor eye contact □abnormal response/interactions with people
□difficult to calm down or comfort □stiff muscle tone □other:

Please check if your child had any feeding problems? ☐with breast feeding ☐With bottle feeding
Describe:

Please check if your child had any sleeping problems? ☐nightmares ☐night terrors ☐other:
Describe:

DEVELOPMENTAL HISTORY

When did you first become concerned about your child's development? Why?

At what age did your child do the following things? (please write your best guess or estimate)

Sit up		Read fairly well		Name all the colors	
Stand alone		Ride a tricycle		Begin toilet training	
Walk alone		Ride a bicycle		Complete day toilet training	
Say a word other than mama or dada		Speak in sentences		Always dry at night	
Drink from a cup		Start school		Begin puberty (or periods)	
Get dressed alone		Count to ten		Have a hand preference (using right or left hand more)	

Has your child had any problems with speech and language development? ☐Yes ☐No

Did you think that your child's motor milestones (rolling, sitting, walking) were: ☐on time ☐early ☐delayed

Has your child received any CDSA, early intervention, or Birth to Three services? ☐Yes ☐No

Have you ever been worried that your child has lost skills that he/she used to have? ☐Yes ☐No
If yes, please explain, including at what age it occurred.

Please check "Yes" or "No" if you have a concern about a skill or ability with your child **compared to others of the same age**.

Skill or Ability	*Yes*	*No*
Gross Motor Skills (throwing, catching, running, jumping)		
Social Skills (sharing, cooperating, taking turns)		
Balance		
Fine motor skills (coloring, drawing, writing, scissors use)		
Learning		
Self Help Skills (dressing, eating, toileting, bathing)		
Understanding spoken instructions		
Expressing self verbally		
Speaking clearly		

At what age level does your child's development seem closest to?

How would you rate your child's overall level of intelligence? ☐ Below average ☐ Average ☐ Above average

TEMPERAMENT

Your Child's Temperament: Please circle any traits that your child has <u>persistently</u> had and indicate with an "√" during what age ranges.

Trait	0-12 months	1-3 years	3-5 years	5-12 years
Highly active, always into things, restless, can't stay seated				
Trouble paying attention, doesn't finish what he/she started, frequently shifts from one thing to another				
Has trouble with changes in daily activities, doesn't like change, inflexible				
Doesn't like new situations, slow to warm up, shy and reserved				
Intense feelings or emotions				
Unpredictable and hard to get on schedule with sleep, appetite, bowels, moods				
Negative mood, hard to please, whiny, unhappy, complains, irritable				
Bothered by sounds, touch, clothes have to feel just right				

MEDICAL HISTORY

Primary Care Provider (PCP):	Location of PCP:
Date of last complete physical examination or well child exam:	

REVIEW OF SYSTEMS: *Check* all significant symptoms your child has had **in the last 6 months**:

√		√		√		√	
	Fever		Constipation		Sore throats		Restlessness
	Appetite change		Diarrhea		Tics		Sleepiness
	Weight loss		Nausea		Tongue Movement		Irritability
	Weight gain		Stomachache		Seizures		Nervousness
	Sleep disturbance		Indigestion		Slurred Speech		Agitation
	Snoring		Stool accidents		Confusion		Skipped heart beats
	Dry mouth		Bed-wetting accidents		Headaches		Racing Heart
	Blurred vision		Daytime wetting		Abnormal Movements		Dizziness

CHILDHOOD ILLNESSES AND PROBLEMS: *Check* and *enter the age* when your child had any of the following:

√		Age:	√		Age:	√		Age:
	Sleeping problems			Eating problems			Vision problems	
	Hearing problems			Migraines			Seizure disorder	
	Poisoning			Asthma			Movement Disorder/Tics	
	Fainting			Ear Infections			ADHD	
	GI problems			Kidney Disease			Urinary problems	
	Diabetes			Thyroid Disease			High Blood Pressure	
	Tumor/Cancer			Liver Disease			Blood disease	
	Meningitis			Head Injury			Loss of Consciousness	
	Failure to Thrive			Broken bones			Measles/Mumps	
	Whooping Cough			Eczema			Chicken Pox/Shingles	
	Heart Disease			Allergies			Learning Disabilities	
	Head Trauma			Cerebral Palsy			Other:	

LEAD EXPOSURE: Do you have concern about your child being exposed to lead? ☐Yes ☐No Why?

Please check any that apply:

- □ My child has lived in or regularly visited a house with peeling or chipping paint built before 1960
- □ My child has lived in or regularly visited a house build before 1960 with recent, ongoing, or planned renovation or remodeling
- □ My child has siblings, housemates, or playmates who is followed or treated for lead poisoning
- □ My child has lived with an adult whose job or hobby involves exposure to lead
- □ My child has lived near an active lead smelter, battery recycling plant, or other industry likely to release lead
- □ My child has been found to have a high blood lead level

Please list any CHRONIC MEDICAL CONDITIONS:

Age:	

Please list any past SURGERIES (PE tubes, tonsils, appendix, oral surgery, circumcision):

Age:	Reason:

Please list any past HOSPITALIZATIONS:

Age:	Reason:

CURRENT MEDICATIONS	Dose	Used for?	How Effective?	Side Effects?

List any allergies to medications:

Medication:	What was the reaction?

Please indicate any…	What therapy?	What is it used for?	How effective is it?	How often is this therapy used?
Homeopathic, naturopathic, herbal and/or other complementary or alternative medicine treatments for physical and/or mental health?				

NUTRITION: How would you describe your child's diet? ☐good ☐fair ☐poor
What types of foods does he/she eat in a typical day for breakfast, lunch, dinner, and snacks?

Do you have any concerns that your child might be using certain substances such as cigarettes, alcohol, marijuana, street drugs, inhalants or others? ☐Yes ☐No

Do you have any concerns that your child might be engaging in high risk behaviors (sexual activity, self-injury, eating disorder, or other)? ☐Yes ☐No

Do you have any concerns that your child is having unusual behavior such as cruelty to animals, fire setting, cruelty to others? ☐Yes ☐No

Has your child ever been a victim of teasing or bullying? ☐Yes ☐No

Do you have any concerns about any type of abuse (physical, sexual, emotional, verbal, neglect) that your child may have experienced or witnessed? ☐Yes ☐No

Please list any Child Protective Services (CPS) or Family Advocacy involvement with your child and/or your child's family:

Please list any legal problems that your child has had (gangs, arrests, juvenile hall):

ADDITIONAL INFORMATION

Is there anything else you would like us to know about your child?

FAMILY HISTORY: (Please check all that apply to the child's family)

	Biological Mother	Biological Father	Sibling(s)	Mother's Family	Father's Family
MEDICAL					
Cancer					
Diabetes					
Genetic Disorders/Birth Defects					
Heart Disease (prior to age 40) or Sudden Death or Unexpected Death or pacemaker placement					
Movement Disorder/Tics					
Seizure Disorder/Epilepsy					
Thyroid Disease					
Cerebral Palsy					
Hearing problems					
Vision problems					
Other Medical Problem:					
SCHOOL					
ADD/ADHD					
Dyslexia					
Mental Retardation					
School/Learning Problems					
Speech & Language Problems					
MENTAL HEALTH					
Alcoholism/Alcohol Abuse					
Anxiety/Panic Disorder					
Autism/Asperger's Syndrome					
Bipolar/Manic Depression					
Dementia/Alzheimer's Disease					
Depression					
Drug Abuse (Which drugs?)					
Obsessive Compulsive Disorder					
Schizophrenia					
Suicide					
Psychiatric Treatment					
Psychiatric Hospitalizations					
LEGAL					
Aggression or Criminal Activity					

SOCIAL HISTORY

Biological Mother's Name	**Date of Birth**	**Education Level**	**Marital Status:** **# of previous marriages:**	**Occupation**
Biological Father's Name	**Date of Birth**	**Education Level**	**Marital Status:** **#of previous marriages:**	**Occupation**

Please list all people whom this child is currently living with?

Name	**Age**	**Relationship to Child**

Is this child adopted? ☐Yes ☐No At what age was this child adopted?
What were the circumstances of the adoption?

What are your child's strengths and talents?

What are your child's favorite activities/hobbies?

List any significant stresses or family problems since your child has been born: (moves, deployments, illnesses, marital conflicts, separations or divorces, family violence, abuse, deaths, financial problems, alcohol or drug problems, etc.)

Do you have any family members in the area that you can rely on for help? □ Yes □ No

Do you have any friends in the area that you can rely on for help? □ Yes □ No

EDUCATIONAL HISTORY ☐ This section does not apply because my child is not in school.

Current School Information:

School:	**Grade:**	**Teacher:**

What are your current concerns for your child's academics?

Does your child have any problems with the following learning tasks?
☐Reading ☐Writing ☐Spelling ☐Math

Does your child have any of the following behavioral problems in the classroom?
☐Inattention ☐Distractibility ☐Hyperactivity ☐Impulsivity ☐Temper Tantrums
☐Disrespect ☐Oppositional/Defiant ☐Aggression ☐Excessive Talking

What are his/her most recent grades? Is this a change? ☐Yes ☐No
Does your child currently have an Individualized Education Plan (IEP) or 504 Plan? ☐Yes ☐No
Does your child get along with his/her teachers? ☐Yes ☐No
Does your child get along with other students? ☐Yes ☐No
What kinds of extracurricular activities (sports, music, clubs, drama, scouts) does your child participate in?

Please check in the appropriate boxes that pertain to your child.

Grade	Unable to pay attention, stay on task, or complete assignments	Problems with learning, low or failing grades	Problems with behavior at school
Preschool			
Kindergarten			
1st grade			
2nd grade			
3rd grade			
4th grade			
5th grade			
6th grade			
7th – 9th grade			
9th – 12 grade			

Has your child ever been suspended or expelled? ☐Yes ☐No

Has your child ever repeated a grade? ☐Yes, indicate which grade:_____ ☐No

Has your child required any special education? ☐Yes ☐No

Has your child been in any advanced programs or skipped a grade? ☐Yes ☐No

IF YOUR CHILD HAS HAD PSYCHO-EDUCATIONAL TESTING (IQ AND ACHIEVEMENT) OR HAS AN IEP OR 504 PLAN, PLEASE ATTACH IT TO THIS QUESTIONNAIRE OR TURN IT IN WITH YOUR PRE-APPOINTMENT PAPERWORK.

Thank you so much for completing this questionnaire.
We look forward to meeting you and your child!