Pediatric Neurology Developmental Questionnaire

Today's Date:

Patient's Name:	Date of Birth:	☐ Adopted ☐ Foster child
Address:		
City:	State:	Zip:
Parent/Guardian:		
Address:		
Home Phone: Email address:	Day Phone:	

Referring Physician, address and phone number:

Who else should receive a copy of the consultation letter? Please give names and addresses.

Who directed you to this clinic?

What do you think is your son/daughter's main problem?

Any specific questions/concerns to be answered by this visit?

Any previous diagnosis? What ? **When and by whom?**

Family Information:

Relation	Name	Age	Level of Education & Occupation	Lives with Patient?
Mother				
Father				
Sibling:				

Other people living in household?

Parent's marital status:
If separated or divorced, with whom is the patient living?
If separated or divorced, who has legal custody of the patient?

Prenatal/ Birth History:

Conception: Normal? Artificial Insemination? In vitro fertilization? What fertility drug, if any, used before/during pregnancy?
Pregnancy: Excessive nausea/vomiting? Gain more than 35lb or less than 10lbs.? Have a special diet? Have RH incompatibility? Rhogam treated? Drink alcoholic beverages? Take medication other than vitamins? Have high blood pressure? Have toxemia? Have severe headaches? Have spotting or bleeding? Have any x-rays Have false labor? Have other illnesses or medical problems? Was your child's movements different than in other pregnancies? Chemical exposures at work? Chemical exposures in the home? Other problems?

Birth History

Hospital City State

Length of pregnancy Length of Labor Induced? Anesthesia?

Birth was ☐Normal ☐Cesarean ☐Breech ☐Twins or multiple births Were forceps used?

Did Baby need medical assistance to start breathing? ☐No ☐Yes, specify:

Apgar scores, if known:

Did Mother have complications? ☐No ☐Yes, specify:

Newborn Period

Birth weight: Was baby in the special care nursery? ☐ No ☐ Yes, specify:

Check any of the following the baby had in the first month of life:

☐ excessive crying	☐ severe diarrhea	☐ skin rash	☐ deformity
☐ jaundice	☐ feeding difficulty	☐ cyanosis (blue baby)	☐ Injury
☐ infection	☐ convulsions/seizures	☐ Antibiotics:	☐ Other:

If so, describe:

Did baby go home from hospital with the mother? ☐ Yes ☐ No, specify:

What was the child like to care for as an infant?

Developmental History:

1. Motor Skills

Please give the ages at which the patient did the following (check "not yet" where appropriate)

Age		Age	
…smiled	☐ not yet	…drew with crayon	☐ not yet
…followed with eyes	☐ not yet	…stood alone	☐ not yet
…reached for objects	☐ not yet	…took first steps	☐ not yet
…rolled over	☐ not yet	…walked alone	☐ not yet
…sat with support	☐ not yet	…ran	☐ not yet
…sat without support	☐ not yet	…rode tricycle	☐ not yet
…crawled	☐ not yet	…rode bicycle	☐ not yet

State any concerns you have over the patient's strength or motor coordination skills:

Does the patient fatigue easily? ☐ No ☐ Yes

Does the patient move about in an unusual or clumsy manner? ☐ No ☐ Yes, specify:

Does the patient use any special equipment (wheel chair, braces, etc.)? ☐ No ☐ Yes, specify:

Hand preference: Right? Left? Not established?

2. Language and Speech

- Number of words patient can say:
- Patient mainly communicates by ☐ crying/vocalizing ☐ babbling
  ☐ gestures ☐ points ☐ pulls person to object of interest
  ☐ single words ☐ two-word phrases ☐ sentences
  ☐ signing ☐ rote phrases ☐ picture communication system
- How does patient use speech? ☐ to express needs ☐ to express emotions
  ☐ to echo another person ☐ to interact with others ☐ to talk about things
- Did patient babble as a baby?
- Age when patient began using single words:
- Age when patient began combining 2-3 words:
- Did patient begin to use words then stop?, ☐ No ☐ Yes, at what age stopped? at what age restarted?
- Are other languages spoken at home? ☐ Yes ☐ No
- Does patient speak clearly (articulate)? ☐ Yes ☐ No
- Does patient respond appropriately when name is called? …when told 'no'?
- Does he/she follow simple commands? …two step commands?
- Do you have any concerns about his/her speech/ language? ☐ No ☐ Yes, specify**:**

3. Sensory

- Is the patient sensitive to sound? ☐ normal ☐ overly sensitive ☐ under sensitive ☐ other, please elaborate:
- Is the patient sensitive to odors? ☐ normal ☐ overly sensitive ☐ under sensitive ☐ other, please elaborate s?
- Is the patient sensitive to being touched? ☐ normal ☐ overly sensitive ☐ under sensitive ☐ other, please elaborate
- Does the patient avoid playing with messy substances(finger paints, paste, etc.)? ☐ No ☐ Yes, please elaborate
- Does patient dislike the feeling of certain types of clothing or material textures? 1 No 1 Yes, please elaborate
- Does patient seek sensory input/stimulation? If so, in what way?
- Does patient avoid foods with certain textures?

4. Development: Self Help Skills

Please give ages at which the patient did the following (check "not yet" where appropriate)

toilet trained-bladder	☐ not yet	dressed self	☐ not yet
toilet trained-bowel	☐ not yet	buttoned clothes	☐ not yet
undressed self	☐ not yet	tied shoelaces	☐ not yet

Do you have any specific concerns about the patient's self-help skills? If so, please elaborate.

5. Development: Emotional Growth

Check any of the following which have been and/or are currently problems with the patient and indicate at what age or ages:

Behavior	Age	Behavior	Age
☐ difficult to discipline	☐ currently	☐ preoccupations	☐ currently
☐ gets upset easily	☐ currently	☐ destructiveness	☐ currently
☐ unusually active	☐ currently	☐ self-injurious	☐ currently
☐ unusually inactive	☐ currently	☐ preferring to be alone	☐ currently
☐ thumb sucking	☐ currently	☐ unusual difficulty with siblings	☐ currently
☐ bed wetting	☐ currently	☐ unusual difficulty with peers	☐ currently
☐ difficulty sleeping	☐ currently	☐ difficulty with opposite sex	☐ currently
☐ nightmares or sleepwalking	☐ currently	☐ repetitive behavior/play	☐ currently
☐ nail biting	☐ currently	☐ repetitive body movements	☐ currently
☐ masturbating excessively	☐ currently	☐ repetitive hand movements	☐ currently
☐ Expresses fears	☐ currently	☐ repetitive use of language	☐ currently
☐ Poor eye contact	☐ currently	☐ Is fascinated with fire	☐ currently
☐ Daydreams	☐ currently	☐ Appears clumsy	☐ currently
☐ Loses belongings	☐ currently	☐ Stutters	☐ currently
☐ Has difficulty finishing what he/she begins	☐ currently	☐ Is verbally aggressive	☐ currently
☐ Fails to follow directions	☐ currently	☐ Is physically aggressive	☐ currently
☐ Forgets	☐ currently	☐ Lies	☐ currently
☐ Has mood swings	☐ currently	☐ Tics	☐ currently
☐ Has difficulty sitting still	☐ currently	☐ problems making or keeping friends	☐ currently
☐ Has tantrums or meltdowns	☐ currently	☐ Seems unaffected by discipline	☐ currently
☐ Avoids or is bothered by certain sensations	☐ currently	☐ Seeks intense sensory stimulation	☐ currently

Comments:

Are there any preoccupations or compulsions? If so please elaborate.

What are the patient's favorite activities?

What are his/her favorite toys?

Does he/she prefer group or individual activities?

Does she/he have friends? ☐ some ☐ none ☐ one or two ☐ many]
Are friends ☐ older ☐ younger ☐ same age ☐ mixed ages

How does he/she get alone with friends?

What are your child's strengths?

Childhood Medical History:

Check any of the following which the patient has had, indicating age and any complications:

Disease/Problem	Age	Complications?	Disease/Problem	Age	Complications?
Measles, Mumps, or Rubella			Frequent falls		
Chickenpox			Accidents/head trauma		
Frequent infections			Unusual severity of common ills		
Meningitis			Ear infections		
Seizures/convulsion			Hearing problems		
Fainting spells			Constipation/diarrhea or other abnormal stools		
Headaches/migraine			Sleep disturbance		
Allergies, Immune problems, eczema			Mono		
Thrush or yeast problems			Strep infection?		
Other?					

Hospitalizations? Please describe problem and dates:

Surgical Procedures? Please describe w/ dates:

Please check off any medical diagnostic tests the patient has had: ☐ MRI ☐ EEG ☐ CT Scan ☐ Blood/Lab work
☐ Other, specify:

Food allergies?

Special dietary restrictions?

Vitamins and Supplements:

Current medications (and dose):

Prior medications:

Any medication allergies?

Has patient had a vision exam? When and what results?

Has patient had a hearing test? When and what results

Are immunizations up to date?

Family Medical History

	ANY MEMBER OF BIOLOGICAL MOTHER'S FAMILY	ANY MEMBER OF BIOLOGICAL FATHER'S FAMILY	SIBLINGS
Alcoholism			
Allergies/ Hay fever			
Asthma			
Ataxia			
Attention deficit			
Autism			
Autoimmune problems			
Bipolar			
Blindness			
Celiac disease			
Cerebral palsy			
Colitis/inflammatory bowel disease/Crohn's			
Compulsions/obsessions			
Deafness			
Dementia			
Depression			
Diabetes			
Eating disorder			
Eczema			
Hormone/endocrine			
Endometriosis/Fibroids			
Food allergies			

Gout/high uric acid level			
Heart disease			
Hives			
Late in learning to talk			
Left handedness			
"Loner" type of person			
Malabsorption (digestive)			
Mental retardation			
Milk or wheat sensitivity			
Movement disorders			
Obesity			
Psychiatric illness			
Schizophrenia/Psychosis			
Seizures			
Significant moodiness			
Speech problems			
Special help in school			
Stroke			
Thyroid disease			
Tics/Tourette's syndrome			
Weakness			
Other			

Educational History

Present school/program:

Address:
How long attended? Grade: Grades repeated:

Description of present school program:

Classification				Classroom setting
Early intervention				
Day Care				
Public	☐ Elementary	☐ Middle	☐ High School	Regular Class
Private	☐ Elementary	☐ Middle	☐ High School	Self-contained Class
Parochial	☐ Elementary	☐ Middle	☐ High School	Integrated Class
Special Collaborative	☐ Elementary	☐ Middle	☐ High School	Mainstream/ Inclusion

Name of patient's teacher Director of Special Education:

Number of children in class:

Number of teachers Number of aides: Number of therapists:

How is your child doing in school, relative to last year?

Has the patient received any of the following therapeutic or remedial services?(check appropriate columns)

Therapy	**In school**	**Out of School**	**Currently**	**Previously**
Speech-Language Therapy				
Physical Therapy				
Occupational Therapy				
Counseling				
Resource Room				
Summer Services				
Other:				

Educational History:

Type of School	**Age/grades**	**Dates**	**Name of schoo/programl, City and State**
Early Intervention			
Preschool			
Elementary: ☐ Public ☐ Private			
Middle School: ☐ Public ☐ Private			
Secondary School ☐ Public ☐ Private			

Previous Diagnostic Testing **(Please list all previous school tests, CORE/Team evaluations, etc**.):

Date Completed	**Discipline Tested**	**Conclusions/Recommendations**

Please bring copies of recent evaluations to your appointment.

Signature of person completing this form:	Relationship to patient:	Date: