

PROFESSIONAL CONSULTING • CLINICAL ASSESSMENT • EDUCATIONAL MAPPING

### Pediatric Questionnaire

By completing this questionnaire prior to your appointment, you will be helping us to better understand your questions and the concerns that are affecting your child and your family. This will also provide us with a great deal of important information, which will allow us to work with you more effectively. Please answer these questions as completely as possible, and bring this form with you to your initial appointment.

Child's name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age of child: \_\_\_\_\_ Sex: \_\_\_\_\_

Handedness: \_\_\_\_\_

Parent(s) name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

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

Date form completed: \_\_\_\_\_

Are you this child's legal guardian?  Yes  No

If you are not the guardian, do you have written consent documenting your right to seek treatment for this child?  
 Yes  No

**PLEASE ATTACH YOUR CHILD'S  
MOST RECENT SCHOOL PHOTO  
HERE.**

#### I. Purpose of Evaluation

Who suggested you get this evaluation?

Please describe the problems that are affecting your child and your family:

When did you first become aware of these problems?

What seems to help the problems?

What seems to make the problems worse?

Has your child received evaluation or treatment for these problems before? If yes, when and with whom?

In what way are you hoping that we can be helpful with these problems?

What do you consider to be your child's best qualities or strengths?



	<i>Yes</i>	<i>No</i>
Were there any problems with the delivery? If yes, please describe the problems (e.g., emergency Cesarean section, slow heart rate, fever, cord around neck, etc.). _____  _____	_____	_____

Apgar scores (if known):      1 minute: \_\_\_\_\_      5 minutes: \_\_\_\_\_

Did your baby require any special care shortly after birth? If yes, please describe the type of care (e.g., phototherapy, blood transfusions, oxygen, incubator, medications,      etc.)  _____  _____	_____	_____
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How long after birth was the baby taken home? \_\_\_\_\_

**III. Medical History**

When was your child's most recent physical? _____ Were there any medical concerns at this time (if yes, please describe) _____  _____	_____	_____
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Has your child ever been hospitalized? If yes, please list ages and reasons: _____  _____  _____	_____	_____
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Has your child ever had surgery? If yes, please list ages and reasons: _____  _____  _____	_____	_____
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Has your child had any serious accidents? If yes, please describe, including ages: _____  _____  _____	_____	_____
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Has your child ever had a seizure or convulsion? If yes, please describe, including ages and medications that were prescribed, if any: _____  _____  _____	_____	_____
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If yes, was the seizure or convulsion associated with a high fever?	_____	_____
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	<i>Yes</i>	<i>No</i>
Has your child had any head injuries? If yes, what happened and when? _____ _____	_____	_____
Was the child unconscious?	_____	_____
Was the child dizzy?	_____	_____
Did the child have a headache afterward?	_____	_____
Did the child vomit afterward?	_____	_____
Does your child have any allergies? If yes, please describe: _____	_____	_____
Does your child have frequent abdominal pains or vomiting? If yes, when does this occur? _____	_____	_____
Does your child have frequent or severe headaches? If yes, how are these treated? _____	_____	_____
Does your child have any other chronic physical complaints? Please specify: _____	_____	_____
Does your child wear glasses/have any vision problems? Please specify: _____	_____	_____
Does your child need hearing aides/have any hearing problems? Please specify: _____	_____	_____
Has your child ever had a hearing exam? If yes, when? _____ What were the findings? _____	_____	_____
Does child have a history of frequent ear infections? If yes, please specify how often and at what ages: _____ _____	_____	_____
If yes, please specify how they were treated (P.E. tubes, antibiotics): _____		
Is your child taking any medications on a regular basis? If yes, please list the medications and reasons child is taking them: _____ _____	_____	_____
Has your child taken any other medications in the past? If yes, please list the medications and reasons child took them: _____ _____	_____	_____

Please list the name, address, and telephone number of the doctor (e.g., pediatrician, family physician) who cares for your child:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone number: \_\_\_\_\_  
 \_\_\_\_\_

**IV. Developmental History**

At what age did your child...  
 (if you are unsure, please estimate)

Roll over	_____	Say single words meaningfully?	_____
Sit without help?	_____	Combine 2 or more words?	_____
Walk without help?	_____	Use sentences?	_____

Compared to other children, do you feel that your child has been **slower** in learning...

	<i>Yes</i>	<i>No</i>
To talk?	_____	_____
To understand?	_____	_____
To build with blocks, play with puzzles, draw pictures?	_____	_____
Gross motor skills (walking, hopping, riding bicycle, etc.)?	_____	_____
Fine motor skills (fastening buttons, zippers, drawing, etc.)?	_____	_____
Early school-related skills (naming colors, saying alphabet)?	_____	_____
To sit still for TV or stories?	_____	_____
Staying with any one activity for a reasonable time?	_____	_____
To play or socialize with other children?	_____	_____

Does your child have or ever had (check all that apply):

Poor handwriting? \_\_\_\_\_ Toe walking? \_\_\_\_\_ Loss of skills? \_\_\_\_\_  
 Blank spells? \_\_\_\_\_ Falling spells? \_\_\_\_\_  
 Tics or twitching? \_\_\_\_\_ Clumsiness \_\_\_\_\_  
 If yes, please clarify: \_\_\_\_\_

As an infant, did your child demonstrate a:  
 \_\_\_\_\_ High activity level (e.g., overactivity)  
 \_\_\_\_\_ Age-appropriate activity level  
 \_\_\_\_\_ Low activity level (e.g., lethargic)

	<i>Yes</i>	<i>No</i>
Has this child had difficulty separating? If yes, at what age: _____	_____	_____
Did your child have any difficulties with early bonding?	_____	_____
Is your child toilet trained? If yes, at what age: _____	_____	_____
Does your child have toileting accidents during the day? If yes, how often: _____	_____	_____

	<i>Yes</i>	<i>No</i>
Does your child have toileting accidents at night? If yes, how often: _____	_____	_____

Has your child had any sleeping difficulties? If yes, please describe: _____ _____	_____	_____
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Has your child had any eating difficulties? If yes, please describe: _____ _____	_____	_____
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Has your child had angry outbursts, temper tantrums, or other behaviors that caused you concern? Describe: _____ _____ _____	_____	_____
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Does your child have the opportunity to play with same-age children?	_____	_____
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Does your child prefer to play with older, younger, or same-age children? _____		
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How does your child occupy him/herself? What toys or activities does your child seem to enjoy?  
\_\_\_\_\_  
\_\_\_\_\_

How does the child respond to discipline? \_\_\_\_\_  
\_\_\_\_\_

Has discipline been frequently necessary? \_\_\_\_\_  
\_\_\_\_\_

Who ordinarily disciplines the child? \_\_\_\_\_  
\_\_\_\_\_

**V. Family History**

Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place of employment: \_\_\_\_\_

Work hours: \_\_\_\_\_ Work phone: \_\_\_\_\_

Father's name: \_\_\_\_\_ Age: \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place of employment: \_\_\_\_\_

Work hours: \_\_\_\_\_ Work phone: \_\_\_\_\_

Step-parent's name (if applicable): \_\_\_\_\_ Age: \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place of employment: \_\_\_\_\_

Work hours: \_\_\_\_\_ Work phone: \_\_\_\_\_

Parents are:

Married: \_\_\_\_\_ Date: \_\_\_\_\_

Separated: \_\_\_\_\_ Date: \_\_\_\_\_

Divorced: \_\_\_\_\_ Date: \_\_\_\_\_

Unmarried: \_\_\_\_\_ Date: \_\_\_\_\_

Widowed: \_\_\_\_\_ Date: \_\_\_\_\_

If parents are divorced, who has legal custody? \_\_\_\_\_

If parents are separated or divorced, please describe physical custody and visitation arrangements?

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

Please list the persons who are currently living in the home with the child:

<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Relationship to child</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any family members who are no longer at home:

<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Relationship to child</u>	<u>When did they leave?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is this child a foster child? Yes \_\_\_\_\_ No \_\_\_\_\_ Is this child adopted? Yes \_\_\_\_\_ No \_\_\_\_\_

If a foster child or adopted, at what age was the child placed with you? \_\_\_\_\_

If a foster child or adopted, has this been discussed with the child? Yes \_\_\_\_\_ No \_\_\_\_\_

If adopted, when was adoption legally finalized? \_\_\_\_\_

If a foster child or adopted, how many placements occurred prior to being placed in your home? \_\_\_\_\_

If there have been previous placements, please list all of the child's placements and length of placement \_\_\_\_\_

How long has the child been living in the current home or apartment? \_\_\_\_\_

How many times has your child been moved during the past 3 years? \_\_\_\_\_

Who provides care for your child while you are at work (if applicable)? \_\_\_\_\_

During the past 12 months, has your family experienced any of the following:

	<i>Yes</i>	<i>No</i>
Death of a family member:	_____	_____
Serious illness:	_____	_____
Unemployment:	_____	_____
Marital problems:	_____	_____
Other (please describe _____)	_____	_____

Has your child ever lost any person with whom he/she seemed to have a close relationship, such as a relative, caretaker, etc.?  
 If yes, at what age(s)? \_\_\_\_\_  
 Who? \_\_\_\_\_

Has your child or family ever been seen by a psychologist, psychiatrist, or counselor?  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list anyone in the family who is left-handed or "mixed-handed:" \_\_\_\_\_  
 \_\_\_\_\_

Please indicate if anyone in the patient's immediate or extended family (parent, grandparent, brother/sister, uncle/aunt) has had any of the following?  
*(if you need more room, please add more comments below this section)*

	<u>Yes</u>	<u>Who?</u>	<u>Explain</u>
Learning problem (e.g., reading, math)	_____	_____	_____
Language difficulties	_____	_____	_____
Hyperactivity (or "ADHD")	_____	_____	_____
Psychiatric problems (e.g., depression, anxiety, "nervous breakdown")	_____	_____	_____
Substance use problems (including alcohol)	_____	_____	_____
Seizures/Epilepsy?	_____	_____	_____
Neurological disease?	_____	_____	_____
Mental Retardation?	_____	_____	_____
Any genetic disorders?	_____	_____	_____

**VI. School History**

	<i>Yes</i>	<i>No</i>
Did your child attend preschool?	_____	_____
If yes, give ages of attendance: _____		
Preschool name: _____		

Age at kindergarten entrance: \_\_\_\_\_

Age at first grade entrance: \_\_\_\_\_

Has your child ever repeated a grade:	_____	_____
If yes, which grade(s): _____		

Has your child been evaluated or tested before?	_____	_____
If yes, when and by whom? _____		
_____		

Has this child had a frequent change of schools?	_____	_____
How many schools has he/she attended? _____		

Current grade placement: \_\_\_\_\_

School name: \_\_\_\_\_

Address: \_\_\_\_\_  
(street)

\_\_\_\_\_ (city)                      (state)                      (zip code)

Has school reported current problems with: (Check)

Reading	_____	Describe: _____
Spelling	_____	Describe: _____
Writing	_____	Describe: _____
Arithmetic	_____	Describe: _____
Social adjustment	_____	Describe: _____
Attention span	_____	Describe: _____
Following directions	_____	Describe: _____

Has your child received any of the following services?

	<i>Yes</i>	<i>No</i>	<i>Ages or Grades</i>
Speech/language therapy	_____	_____	_____
Physical therapy	_____	_____	_____
Occupational therapy	_____	_____	_____
Learning disabilities tutoring	_____	_____	_____
Counseling	_____	_____	_____
Other (please describe: _____)	_____	_____	_____

Has your child ever been placed in any of the following special educational programs?

	<i>Yes</i>	<i>No</i>	<i>Ages or Grades</i>
Developmental/transitional	_____	_____	_____
Emotional handicapped	_____	_____	_____
Mild mental handicapped/retardation	_____	_____	_____
Moderate mental handicap/retardation	_____	_____	_____
Severe/profound mental handicap/retardation	_____	_____	_____
Learning disabilities resource room	_____	_____	_____
Multiple handicapped	_____	_____	_____
Hearing impaired	_____	_____	_____
Visually impaired	_____	_____	_____
Have you requested an evaluation through your school?	_____	_____	_____

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Thank you for taking the time to complete this questionnaire. I look forward to seeing you on your appointment date.

\_\_\_\_\_  
(signature of parent/guardian)

\_\_\_\_\_  
(today's date)

\_\_\_\_\_  
(city, state, zip code)

\_\_\_\_\_  
(telephone number)