PAA – Developmental Pediatrics Intake Questionnaire

In order to provide the most accurate diagnoses and helpful recommendations, we will need information about your child and family. Thank you for completing this questionnaire and bringing it to (or faxing it before) your first appointment. Use separate sheets of paper if more space is required. This record will remain confidential in your child's record.

Child's Name	Child's birth date	Age	Today's date:
Home Address			Phone ☐home ☐cell
			E-Mail

Name of Person Completing this form:	Relationship to child:
Current medical provider: ___________________________ Address: Phone: Fax:	Who referred your child to us?_______________________________ Address: Phone: Fax:

What questions or concerns do you have about your child?

To date, what has been done about your concern(s) and with what results?

MEDICAL

Gestation

Mother's: Previous pregnancies #_________ Subsequent pregnancies #________ Not completed #________________

Month of pregnancy when prenatal care started ______________ Weight gain during pregnancy: ____________

Complications during the pregnancy (*infertility treatment*, *bleeding, high blood pressure, diabetes, trauma, blood type incompatibility, fevers, rashes, thyroid problems, stresses, hospitalizations, seizures, trauma, etc*.):

During the pregnancy was there any exposure of the baby to:

☐ Alcohol ☐ Smoking ☐ Street drugs ☐ Medications ☐ Trauma

Medications that the mother took during the pregnancy:

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

Birth

On the day of delivery: Mother's age ____ Father's age _____ Length of pregnancy? __________weeks

Any problems with the delivery? (*emergency c-section, forceps/vacuum, breech, multiple births, premature rupture of membranes, failure of labor to progress, maternal fever, abnormal bleeding, breech, need for resuscitation, abnormalities noted at birth, other*)?

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

Any problems while the baby was in the hospital? (*needed oxygen, on ventilator, jaundice, seizures, birth defects, blood transfusion, feeding problems, abnormal muscle tone, infections, meningitis, respiratory distress, low blood sugar, problems with growth, abnormal head ultrasound or imaging, other.*)

Illnesses (*ear infections, high fevers, asthma, pneumonia, heart problems, anemia, seizures, etc*):

Chronic medical conditions:

Surgeries (*PE tubes, tonsils, appendix, oral surgery*, etc):

Serious injuries (*concussions, broken bones, auto accidents, etc*)

Hospitalizations: Age Reason Length of stay

Allergies:

Current medications Dose Effective? Side effects?

Orthotics / Durable medical equipment / supplemental oxygen /g-tube / tracheostomy?:

Diet: □ typical □ restricted/picky □ vegetarian/vegan □ other ______________________

Immunizations: □ up to date □ need updating □ not given because of____________________________

Previous specialty evaluations (*cardiology, neurology, psychology, GI, etc*) and diagnoses:

Audiology evaluations (age):

Ophthalmology evaluations (age):

DEVELOPMENT

Any concerns about your child's early development?

☐ N ☐ Yes starting at about what age?_______; Main concern was with _______________________________________

Estimate of your child's current development: ☐ below age level ☐ at age level ☐ above age level

Any loss of skills that s/he used to have?

At what age did your child start to do the following things?

Smile at you		Babble (bababa, gagaga, etc)		Play pat-a-cake or peek-a-boo	
Call you "mama"/"dada"		Say 1st word (noun)		Follow a simple command	
Point to body parts when asked		Say 2-word phrases		Say "I" and "you"	
Say 3-word sentences		Say first name on request		Say hundreds of words	
Say correct age		Say first and last names		Tell stories, tell what happened	
Transfer hand to hand		Finger feed		Toss objects overhand	
Try to spoon feed		Imitate housework		Try on a hat	
Use a spoon skillfully		Wash and dry hands at sink		Toilet train	
Dress alone		Get shoes on correct feet		Spread with knife	
Roll both ways		Sit steady		Walk 4-5 steps	
Run		Pedal a trike		Hop 4-5 times on one foot	
Point to show you things		Play pretend		Join other children in a game	

Any problems with speech and language development?

What percent of your child's speech do you understand? ☐ 25 ☐ 50 ☐ 75 ☐ 100

Any problems with social interaction?

Has your child had any of these symptoms over the past couple of months?

Chest pain		Dizziness/fainting		Racing heart/skipped beats		Difficulty with exercise	
Constipation		Diarrhea		Stomachache		Vomiting/nausea	
Headaches		Poor coordination		Tics (motor, vocal)		Muscle weakness	
Sleepy/too tired		Poor sleep		Snoring		Sleep Apnea	
Urinary problems		Day/night wetting		Poor bowel control		Blood in urine/stool	
Shortness of breath		Cough/wheezing		Rashes		Birthmarks	
Arthritis		Leg pains		Fevers		Heat/cold intolerance	
Excess weight gain		Excess weight loss		Poor appetite		Vision/hearing changes	

Behavior:

Describe your child's early behavior, temperament, and adjustment in the first 6 months of life:

☐ Colic?	☐ Feeding problems? (☐ With breast feeding ☐ With bottle feeding)
☐ Day/night confusion?	☐ Reflux ☐ formula changes needed

Any current sleeping problems? ◻ nightmares ◻ night terrors ◻ sleep walking
◻ trouble falling asleep ◻ nighttime waking ◻ hard to awaken in the morning

Other:

How would you describe your child's personality?

What are his/her strengths and talents?

What are his/her favorite activities/hobbies?

Does your child have as many friends as most other children of same age?

How does s/he interact with friends? ☐ in person ☐telephone ☐ e-mail/chat/text

Any difficulties with social interaction?

What types of discipline do you use and how does your child respond?

Does s/he have any current or recent problems with:

Hyperactivity		Defiance/anger		Daytime wetting		Anxiety	
Impulsivity		Cruelty to animals		Nighttime wetting		Depression	
Short attention span		Self-injury/cutting		Bowel problems		Obsessive/compulsive	
Distractibility		Setting fire		Soiling self		Tics	
Recklessness		Physical aggression		Cutting		Excessive moodiness	
Being emotional		Being shy/reserved		Being inflexible		Must be the boss	
Nightmares		Insomnia		Daytime sleepiness		Panic attacks	

Other behaviors of concern to you:

SOCIAL

Caregiver #1 ☐child lives with ☐married ☐single parent ☐divorced

Name	Age	Educational level
Relationship to child: ☐mother ☐father ☐stepmother ☐stepfather ☐adoptive parent ☐foster parent ☐other____________________		
Address		Phone ☐home ☐cell
Occupation	Employer	

Caregiver #2 ☐child lives with ☐married ☐single parent ☐divorced

Name	Age	Education level
Relationship to child: ☐mother ☐father ☐stepmother ☐stepfather ☐adoptive parent ☐foster parent ☐other____________________		
Address		Phone ☐home ☐cell
Occupation	Employer	

Siblings and others (other than parents) living in the home:

Name	**Age**	**Relationship**

Is your child adopted? At what age? Circumstances:

Moves since birth?

Significant family stresses lately?

Child's current activities (*scouts, sports, etc):*

Family activities done together:

Are parents separated ☐ divorced ☐ ? How old was your child when that happened? ________

How is custody/visitation divided?

Other social concerns:

EDUCATION

Current school: Address: Phone: Fax:	Grade level:

Enrolled in early intervention services? Ages enrolled: (*please bring IFSPevaluation results if available*)

Enrolled in preschool special education? Ages enrolled: (*please bring IEP evaluation results if available*)

Current problems with learning:

Reading		Writing		Comprehension	
Spelling		Math		Speech/Language	

Current behavioral problems in the classroom?

Inattention		Impulsivity		Aggression	
Distractibility		Disrespect		Talking out	
Hyperactivity		Oppositionality		Bothering others	

Past school history:

Grade	**School/ location**	**Learning problems, struggling**	**Poor attention, off task, not finishing work**	**Disrupting, out of seat, talking out, clowning**	**On IEP?**
Preschool					
Kindergarten					
1st grade					
2nd grade					
3rd grade					
4th grade					
5th grade					
6th grade					
7th – 9th grade					
9th – 12 grade					

Has s/he been suspended or expelled from school (or bus, or after-school programs)?

Has s/he repeated a grade?

Has s/he been in an advanced academic program or skipped a grade?

Extracurricular activities (*sports, music, clubs, drama*)?

How does s/he get along with teachers?

How does s/he get along with other students?

Have his/her grades fallen off recently?

Recent teacher reports (*e-mail reports, parent-teacher meetings, phone calls, etc*):

FAMILY

(Parents, siblings, cousins, aunts/uncles, grandparents, great-aunts/uncles with any of the following)	Mother	Father	Sibling	Mother's Family	Father's Family
Late to walk or talk					
Learning disabilities					
ADHD					
Dyslexia					
School problems/special ed					
Speech/Language Problems					
Autism					
Cerebral Palsy					
Intellectual disabilities (retardation)					
Blindness					
Deafness					
Seizure Disorder/Epilepsy					
Thyroid Disease					
Cleft palate					
Substance Abuse (alcohol,drugs)					
Anxiety/Panic Disorder					
Depression					
Bipolar disorder					
Obsessive Compulsive Disorder					
Schizophrenia					
Suicide or attempts					
Criminal activity					
Early heart attacks/sudden death					
Miscarriages/stillbirths					
Birth defects					

Additional information:

Please bring to (or fax before) your appointment Fax: 703-922-6067

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