



## Developmental Pediatrics and Pediatric Psychology Parent Questionnaire for Birth through 3 Years Old

To help us better plan for your child's evaluation, please provide the following information.

Greenville: (864) 454-5115

Columbia: (803) 434-6598

### General Information

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date \_\_\_\_\_ Form Completed by \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Parent 1 Name \_\_\_\_\_ Parent 2 Name \_\_\_\_\_

Other Caregiver(s): \_\_\_\_\_

Legal Guardian of Child: \_\_\_\_\_ Relationship \_\_\_\_\_

Circle One:    Biological    Adopted    Foster

What is the primary language spoken at home? English \_\_\_\_ Spanish \_\_\_\_ Other \_\_\_\_\_

What concerns about your child would you like us to address? \_\_\_\_\_

### Has your child been previously diagnosed with any of the following? (check all that apply):

Autism     Learning Disability     ADD/ADHD     Other \_\_\_\_\_

Where does your child attend daycare or preschool? \_\_\_\_\_

How long has your child been at this daycare/preschool? \_\_\_\_\_

### Has your child received any therapy or services from the following? (check all that apply):

<input type="checkbox"/> BabyNet / EI / DDSN	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> School
<input type="checkbox"/> Psychologist	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Counseling
<input type="checkbox"/> Psychiatrist / Mental Health	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other:

### Pregnancy, Birth, and Health History

When was prenatal care begun? \_\_\_\_\_ Biological mother's age when child born: \_\_\_\_\_

How long was the pregnancy? Full Term \_\_\_\_\_ Other (indicate how long) \_\_\_\_\_

Type of Delivery: Vaginal \_\_\_\_\_ Scheduled Caesarean \_\_\_\_\_ Emergency Caesarean \_\_\_\_\_

Complications at delivery: Cord Around Neck \_\_\_\_\_ Breech \_\_\_\_\_ Forceps/Vacuum \_\_\_\_\_  
 Infant injured during delivery \_\_\_\_\_ Trouble breathing \_\_\_\_\_ Swallowed or aspirated fluid/meconium \_\_\_\_\_  
 Was your baby in the NICU/Special Care Nursery? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how long? \_\_\_\_\_  
 Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Head Circumference \_\_\_\_\_

During the pregnancy did the mother? (Only check if yes, and provide details):

	Yes	Details
Have to be hospitalized (if yes, why)		
Drink alcoholic beverages (if yes, how much)		
Smoke (if yes, how much)		
Use medications other than prenatal vitamins		
Use illegal/street drugs (if yes, list drugs)		
Other (please explain)		

During the newborn period, did your baby have any of the following health problems?

Problem	Yes	No	Explain
Have to be on a ventilator			How long? 0-7 days ___ 7-14 days ___ 14-21 days ___ >21 days ___
Require oxygen in hospital			How long? 0-7 days ___ 7-14 days ___ 14-21 days ___ >21 days ___
Have any seizures			
Have any brain abnormalities			
Have any heart problems			
Have any other birth defects			

Other concerns around the time of delivery: \_\_\_\_\_

### Developmental History

During the first 12 months, were there problems in any of the following areas? If yes, please describe.

Feeding \_\_\_\_\_

Sleep: \_\_\_\_\_

Difficulty comforting/ excessive crying: \_\_\_\_\_

Eye contact/ social interaction: \_\_\_\_\_

Please give age at which the child did the following. If you do not remember the exact age, give approximate age. You can leave blank or write N/A if the item does not apply to your child.

Language	age	Motor	age	Self-help skills	age
Said "mama"/ "dada"		Rolled over		Fed self	
First word		Crawled		Tied shoes	
Combined words (i.e. car go)		Walked alone		Toilet trained	
Pointed to body parts		Held bottle			
Pointed to pictures		Scribbled spontaneously			

How old do you feel your child acts? \_\_\_\_\_

Has your child lost any ability that she/he could previously do? \_\_\_\_\_

## Medical History

Has your child had any of the following?	Yes	No	Age
Convulsions, seizures, fainting spells			
Hearing problems			
Traumatic injury to the head or neck			
Vision problems			
Has your child had any of the following?	Yes	No	Age
Any surgeries?			
If yes, what & when			
Any other medical diagnoses?			
If yes, describe			
Names of other doctors your child sees			

### Medications that your child is on now (list any additional medications on a separate page):

Names of Medication	Dose	Side effects noted	Response to medication

### Medications previously taken regularly by your child (list any additional medications on a separate page):

Names of Medication	Dose	Side effects noted	Response to medication

## Social History

Who lives at home? \_\_\_\_\_

Caregiver / Parent 1 age: \_\_\_\_ School level completed: \_\_\_\_ Present Occupation: \_\_\_\_\_

Caregiver / Parent 2 age: \_\_\_\_ School level completed: \_\_\_\_ Present Occupation: \_\_\_\_\_

Family stresses	Yes	No	Explain
Have there been any changes in family circumstances?			
Has there been a loss or change in job status?			
Has there been a recent addition or loss of family members?			
Has your child changed schools or daycare?			
Has anyone close to your child died recently?			
Have you moved in the last 12 months?			
Has your child had any DSS investigation?			

## Family History

Please complete the below for brothers and sisters of child (include ½ brothers and sisters):

Name	Age	Relationship	Development/Learning (normal/advanced/delayed)	Any diagnoses

Please check if any of the child's biological relatives have had any of the following conditions:

	ADHD	Anxiety	Depression	Bipolar	Learning Problems	Autism	Alcohol Abuse	Drug abuse	Developmental Delay	Genetic Disorders	Seizures
Mother											
Father											
Sister (s)											
Brother(s)											
Maternal Aunt											
Maternal Uncle											
Paternal Aunt											
Paternal Uncle											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											

If you have any additional comments, please list them here (attach extra pages if necessary). \_\_\_\_\_

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