PRISMA HEALTH
Children's Hospital

Developmental Pediatrics and Pediatric Psychology
Parent Questionnaire for Ages 4 and Older

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 _____

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

Pregnancy, Birth, and Health History

	BabyNet / EI / DDSN
	Psychologist
	Psychiatrist / Mental Health
	ABA Therapy

	Speech Therapy
	Physical Therapy
	Occupational Therapy

	School
	Counseling
	Other:

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: Yes _____ No _____ If yes, please describe _____

_____

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 child have any problems? If yes, please explain.

_____

Feeding _____

Sleep _____

Difficulty comforting/ excessive crying _____

Eye contact/ social interaction _____

Developmental History

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 (ie. car go)		Walked alone		Toilet trained	
Pointed to body parts		Held bottle			
Pointed to pictures		Scribbled spontaneously			

How old does your child act? _____

Do you have any general questions or concerns about delays in speech, motor, cognitive, or self-help skills?

_____

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			
Sleep concerns			
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's age: ____ School level completed: ____ Present occupation: _____

Caregiver/Parent 2's 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?			

Family History

Please complete 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	Develop-mental 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											

School History *(leave blank if your child does not attend school)*

Where does your child attend school?_____Current grade:_____

Has your child repeated a grade?_____If yes, which one?_____

Has your child ever been suspended or expelled from school? Yes_____No____If yes, why? _____

How long does your child spend on homework?_____

Do you think your child could complete homework in less time? Yes____No____If no, why?_____

What were your child's grades on the most recent report card?

Language Arts_____Math_____Science_____Spelling_____Social Studies/History_____

Has your child ever received Special Education services or resource? Yes_____No____ Which grade(s)? _____

Does your child currently have an Individualized Education Plan (IEP)? Yes_____No____

If yes, please describe:_____

Does your child currently have a 504 plan? Yes _____ No_____

If yes, please describe:_____