Parent Questionnaire for New Patients

Dear Family,

Your child's pediatrician has suggested a visit to our clinic. In order to do this, we need some more information about your child. This will help us to make sure your child gets the right kind of visit.

Please send the following:

1. Most Recent School or Early Intervention Testing
2. Current IEP or 504 Plan
3. This questionnaire (completed by parent/guardian).
4. The educational questionnaire completed by a member of your child's Early Intervention or school team.

If you have questions about this form or need help filling it out, please call our office at **(585) 275-2986**.

All forms are needed before we can place your child on our wait list.

Please send completed forms to:

Intake Coordinator
Developmental Behavioral Pediatrics
601 Elmwood Avenue, Box 278877
Rochester, NY 14642
Fax: (585) 742-4217
DBPintake@URMC.rochester.edu

Consent for Evaluation

I request that my child _____(Name) be evaluated by Developmental and Behavioral Pediatrics at Golisano Children's Hospital. I understand that Developmental and Behavioral Pediatrics is a training facility and that trainees supervised by faculty may be utilized to administer some evaluations.

If there is joint custody, signatures are required from both parents.

_____ _____
Parent/Caregiver Signature *Date*

_____ _____
Parent/Caregiver Signature *Date*

Child's name _____ Child's date of birth _____

Child's address (street) _____ Date form completed _____

City, state, Zip: _____ Medical Insurance company: _____

Policy Number: _____

Parent or Guardians

Name	Relationship to child (check all that apply)	Phone numbers
	☐ Biologic parent ☐ Foster Parent ☐ Adoptive Parent ☐ Relative ☐ Guardian ☐ Grandparent ☐ Other	(H) (C)
	☐ Biologic parent ☐ Foster Parent ☐ Adoptive Parent ☐ Relative ☐ Guardian ☐ Grandparent ☐ Other	(H) (C)
Employers	Guardian 1:	Guardian 2:
Does child have a Care Coordinator or Case Worker helping with appointment? ☐ No ☐ Yes, Name:		Phone #:

Home Information

Main language used at home	☐ English ☐ Spanish ☐ American sign language ☐ Other:

Who else lives at home with this child?

Name	Age	Relationship to child	Are there any living arrangements (for example, shared custody or foster care), custody issues, parental disagreement about care, or orders of protection that we should be aware of?

Do any family members receive care from us currently?: ☐ Yes ☐ No Who?

What is the ***reason*** you would like your child seen? What are your goals for the visit?

Are you wondering about a certain diagnosis? If yes, what diagnosis? ***What do you see that makes you concerned?***

Has your child ever been diagnosed by a healthcare provider with a developmental or behavioral disorder? Yes ☐ No ☐

☐ Autism ☐ ADHD ☐ Cerebral palsy ☐ Anxiety disorder ☐ Down syndrome ☐ Other:

Who made the diagnosis and when?

Tell us about the child's **strengths**. What is your child good at? What are their interests? What things are going well?

Parent/Guardian Concerns

What concerns do you have about your child? Please check the areas in which you have concerns.

	Concern	Describe what you see:
☐	Sitting, walking, running, moving	
☐	Using hands and fingers, writing, using utensils	
☐	Communication/Language	
☐	Thinking, learning, and memory	
☐	Social skills, play skills	
☐	Short attention span, easily distracted	
☐	Anxiety, too many worries	
☐	Repeating motor movements (pacing, rocking, hand flapping)	
☐	Intense or unusual interests	
☐	Mood swings/Tantrums	
☐	Aggression (hurts others)	
☐	Self-injury (bangs head, hits self, bites self)	
☐	Sensory issues	
☐	Sleep problems	
☐	Feeding Problems	
☐	Safety problems (running off from caregiver, putting non-food things in mouth)	
☐	High activity level, impulsive	

Developmental History: At what age were you first concerned about your child's development?

Has your child has ever lost skills he or she once had? For example, learned words and then stopped talking? IF yes, what age?

Does your child…	Yes	No	At what age did your child start doing this?
Walk without holding on?	☐	☐	
Use single words?	☐	☐	
Use phrases to talk?	☐	☐	
Use the toilet?	☐	☐	

PREGNANCY (*This can be important even for older children and adopted children!)

The following questions are about the pregnancy ***of the child being evaluated***:

Did child's biologic mother receive prenatal care?	☐ Yes	☐ No	☐ Unsure
Were there any complications during pregnancy? If "Yes", please describe:	☐ Yes	☐ No	☐ Unsure
How many weeks or months along was pregnancy recognized (when did the biologic mother find out she was pregnant)?			
Knowing about exposures to medicines and other substances during this child's pregnancy can sometimes help with the evaluation. Please mark known exposures:			

	Before pregnancy was known	Early in pregnancy	Middle of pregnancy	Late pregnancy	Not at all	Unknown
Prescription medicines (List):	☐	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐	☐
Marijuana/THC	☐	☐	☐	☐	☐	☐
Heroin or fentanyl	☐	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐	☐
Methamphetamine	☐	☐	☐	☐	☐	☐
Other (List):	☐	☐	☐	☐	☐	☐

BIRTH: Birth Weight: _____(lb/kg) Birth length _____(in/cm) Head Circumference: _____(in/cm)	
Was this child…	☐ Single birth ☐ One of twins ☐ Other multiple
Was this child born by…	☐ Vaginal delivery ☐ C-section
Were there any labor/delivery complications?	☐ Yes ☐ No If "Yes", please describe:
Was the baby born premature? If Yes, how many weeks gestation?	☐ Yes ☐ No ☐ Unsure
Was your child admitted to the Special Care Nursery or NICU (neonatal ICU)?	☐ Yes ☐ No ☐ Unsure If "Yes", please describe:
When discharged from the hospital, who did your child go home with?	☐ Parents ☐ Foster Parents ☐ Grandparents ☐ Other relative

CURRENT HEALTH:

What medicines, vitamins, and nutrition supplements does your child take each day?

Medicine name or vitamin/supplement name and brand	Dose (how many mg and how often)	Reason and who writes prescriptions

Does your child eat a special diet or have any food restrictions? Please describe.

Does your child have any ongoing health problems?

☐ Seizures ☐ Cardiac Problems ☐ Constipation or other GI problems ☐ Other, Please describe:

Do you have any concerns about your child's hearing? ☐ Yes ☐ No ☐ Unsure

Do you have any concerns about your chld's vision or ability to see? ☐ Yes ☐ No ☐ Unsure

Has your child ever had a high lead level? ☐ Yes ☐ No ☐ Unsure

Has your child ever been admitted to the hospital overnight or had surgery?

Age	Reason

Does your child see any other specialists?	☐ Yes ☐ No ☐ Unsure
If "Yes", what specialties? (Psychiatrist, Neurology, GI, etc.)	

Family History: Does anyone in the child's biologic family have any of the following:

	Relationship to Child:
ADHD	☐ Yes ☐ No ☐ Unsure
Anxiety/OCD	☐ Yes ☐ No ☐ Unsure
Autism Spectrum Disorder	☐ Yes ☐ No ☐ Unsure
Cerebral Palsy	☐ Yes ☐ No ☐ Unsure
Deafness present at birth or in childhood	☐ Yes ☐ No ☐ Unsure
Depression/Mood disorder	☐ Yes ☐ No ☐ Unsure
Heart problems in young person (Congenital heart disease, arrhythmias, cardiomyopathy, sudden death)	☐ Yes ☐ No ☐ Unsure
Intellectual Disability or Learning Disability	☐ Yes ☐ No ☐ Unsure
Schizophrenia or psychosis	☐ Yes ☐ No ☐ Unsure

Seizures	☐ Yes ☐ No ☐ Unsure
Speech delay or disorder	☐ Yes ☐ No ☐ Unsure
Substance Use Disorder	☐ Yes ☐ No ☐ Unsure
Tremor or other problems moving muscles	☐ Yes ☐ No ☐ Unsure
Other developmental or genetic disorders:	

Child Experiences and Social History Has your child experienced any of the following **since birth?**

Serious illness, surgery, or hospitalization?	☐ Yes ☐ No ☐ Unsure
Serious illness, surgery, or hospitalization of a caregiver?	☐ Yes ☐ No ☐ Unsure
Death of a caregiver?	☐ Yes ☐ No ☐ Unsure
House fire, flood, storm, or other disaster?	☐ Yes ☐ No ☐ Unsure
Divorce of parents or caregivers?	☐ Yes ☐ No ☐ Unsure
Alcohol or drug abuse by a caregiver or member of household?	☐ Yes ☐ No ☐ Unsure
Seeing caregivers hitting/hurting each other?	☐ Yes ☐ No ☐ Unsure
Serious mental health diagnosis of a caregiver?	☐ Yes ☐ No ☐ Unsure
Parent or caregiver in jail or prison?	☐ Yes ☐ No ☐ Unsure
Seeing violence in the community (robbery, shooting, etc.)?	☐ Yes ☐ No ☐ Unsure
Neglect (adult caregiver not giving the child the care he/she needs)?	☐ Yes ☐ No ☐ Unsure
Physical abuse?	☐ Yes ☐ No ☐ Unsure
Sexual abuse?	☐ Yes ☐ No ☐ Unsure
Placement in foster care?	☐ Yes ☐ No ☐ Unsure
Change in primary caregiver?	☐ Yes ☐ No ☐ Unsure

For children in the care of a relative, adoptive or foster parent, or someone who is NOT the biologic parent…

How old was the child when placed in your care?	
Describe what led to you caring for this child.	
If this child has lived with others who are not the biologic parents, please list who and when.	

Home and Community Supports	**Name/address**	**Phone number**
Individual therapy/psychiatrist/ behavior intervention/counseling ***(A treatment summary from the child's therapist is VERY important to our evaluation; please include with the information you send us!)***		
OPWDD services/SPOA services/Care Manager		

If you would like to provide additional information, please feel free to attach additional pages.