Pediatric History Questionnaire
Developmental-Behavioral Pediatrics Clinic
Children's Medical Center Dallas

Please print and fill out this form as completely as possible. Fax the completed form to (214) 867-5461, attention to DBP Clinic. If you have any questions, please call (214) 456-5558.

Patient Name: _____ Patient DOB: _____

Dear Parent/Guardian:

This questionnaire will provide us with important information regarding your child's birth, early medical history, education, and medical issues surrounding their medical condition, which will allow us to work with you more effectively. By completing this questionnaire prior to your appointment, you will be helping us to better understand your questions and the concerns which are affecting your child and your family. Based on the age of your child some of the questions /information requested may not be appropriate. Please answer these questions as completely as possible. Thank you for your time.

Today's Date: _____

Patient's Gender: ☐ Male ☐ Female

Mother's Name: _____ Father's Name: _____

Stepmother's Name: _____ Stepfather's Name: _____

Guardian's Name (if different than above)

_____

Home Address: _____

_____ _____ _____ _____
City State Zip County

Telephone Numbers:

Mother's Home #: _____ Father's Home #: _____

Mother's Cell #:_____ Father's Cell #: _____

Mother's Work #: _____ Father's Work #: _____

Name of Person Completing this form _____

Relationship to Child (parent, guardian, foster-parent etc.) _____

Child's Pediatrician: _____Phone#: _____

Address: _____

Please list the name, specialty, hospital or program affiliation, and address of any other physicians currently providing medical care to your child.

Physician's Name	Specialty	Hospital/Program Affiliation	Address (if available)
1.			
2.			
3.			
4.			

Cultural History:

Which of the following best describes your child? (place a check mark)

White, not of Hispanic origin	
African-American or Black, not of Hispanic origin	
Hispanic	
Native American Indian or Alaskan Native	
Asian, Asian-American, or Pacific Islander	
Other	

Which of the following best describes the child's father? (place a check mark)

White, not of Hispanic origin	
African-American or Black, not of Hispanic origin	
Hispanic	
Native American Indian or Alaskan Native	
Asian, Asian-American, or Pacific Islander	
Other	

Which of the following best describes the child's mother? (place a check mark)

White, not of Hispanic origin	
African-American or Black, not of Hispanic origin	
Hispanic	
Native American Indian or Alaskan Native	
Asian, Asian-American, or Pacific Islander	
Other	

Predominant language spoken in your home:

English	
Spanish	
Other	

What is your child's best language, what language does your child feel most comfortable speaking in?

English	
Spanish	
Other	

Are there other languages spoken in the home? ☐ No ☐ Yes

If yes please list: _____

Referral History (Please be SPECIFIC):

1. Who referred your child to this clinic? _____
   _____
2. Why were you referred to this clinic? _____
   _____
3. Describe the problems that are affecting your child and your family. _____
   _____
4. When did you first become aware of these problems? _____
   _____
5. What seems to help the problems? _____
   _____
   _____
6. What seems to make the problems worse? _____
   _____
   _____
7. Have these problems changed since you first noticed them? If yes, how? _____
   _____
8. Has your child received an evaluation or treatment for these problems before? ☐ yes ☐ no
   A. If yes, when and with whom? **Please provide a copy of any prior evaluations including any school evaluations (MET's or IEP's)** _____
   _____
9. Do you or the school have any concerns about your child's behavior? ☐ yes ☐ no
   If yes, please explain. (i.e., What are the concerns, when did these concerns begin.)
   _____
   _____
10. What do you hope to learn or gain from this visit? _____
    _____
    _____

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

12. Please list your child's strengths: _____
_____

Family History:

Mother's Name: _____ Age: _____

Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation: _____
Place of Employment: _____

Father's Name: _____ Age:_____

Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation: _____
Place of Employment: _____

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

Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation: _____
Place of Employment: _____

Parents are:

Married	☐ yes	☐ no	Date: _____
Separated	☐ yes	☐ no	Date: _____
Divorced	☐ yes	☐ no	Date: _____
Unmarried	☐ yes	☐ no	Date: _____
Widowed	☐ yes	☐ no	Date: _____

Family History (continued):

- If parents are divorced, who has legal custody? Mother Father Joint Other If other, please specify: _____

- If parents are separated or divorced is there any disagreement regarding whether the child should receive clinical services through our department? ☐ yes ☐ no

- If parents are separated or divorced is there a court ordered parenting plan or divorce decree that outlines parental rights related to the child's medical care? ☐ yes ☐ no

- Are you hoping to use this evaluation in any legal proceedings ? ☐ yes ☐ no

- ***Please provide documentation regarding custody, we may not be able to evaluate your child unless this has been received.***

- If parents are divorced or separated, how often does the child visit the parent that he or she does not live with?

  _____
  _____

- Is this child a foster child? ☐ yes ☐ no

- Is this child adopted? ☐ yes ☐ no
  If yes, please give as much information regarding biological parent(s) as you can: _____
  _____
  _____
  _____

- If a foster child or adopted child, how long has the child been in your home? _____

- If a foster child or adopted child, is this child aware that they are a foster child or adopted?
  ☐ yes ☐ no

Who is living in the home at this time? (Please include everyone).

Name	Age	Relationship to Child
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

- Family members living outside of the home. (For example, a biological parent, brothers or sisters).

Name	Age	Relationship to Child
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

- How many times has the child moved during the past 3 years? _____

Family History (continued):

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

			Who (relationship to child)
Death of a family member	☐ yes	☐ no	_____
Serious Illness	☐ yes	☐ no	_____
Unemployment	☐ yes	☐ no	_____
Marital Problems	☐ yes	☐ no	_____
Psychiatric Problems	☐ yes	☐ no	_____
Alcohol/Drug Problems	☐ yes	☐ no	_____
Legal Problems	☐ yes	☐ no	_____

_____

Has anyone in your family experienced the following:

			Which Family Member?
• Speech or language problems	☐ yes	☐ no	_____
• Held back in school	☐ yes	☐ no	_____
• Mental retardation	☐ yes	☐ no	_____
• ADHD (Attention Deficit Hyperactivity Disorder)	☐ yes	☐ no	_____
• Autism	☐ yes	☐ no	_____
• Learning Disabilities	☐ yes	☐ no	_____
• Genetic disorder	☐ yes	☐ no	_____
• Suicide or attempted suicide	☐ yes	☐ no	_____
• Depression	☐ yes	☐ no	_____
• Anxiety	☐ yes	☐ no	_____
• Diagnosed with Manic-Depression	☐ yes	☐ no	_____
• Seizures ("fits")	☐ yes	☐ no	_____
• Neurological disease/disorder	☐ yes	☐ no	_____
• Other health problems	☐ yes	☐ no	_____

- Please list anyone in the family who is left-handed or ambidextrous (mixed-handed):
  1._____ 3._____
  2._____ 4._____

Medical History:

A. Pregnancy and Delivery – this section is to be completed by the child's mother if possible.

Length of pregnancy (how many weeks/months?) _____
Did you attend regular prenatal care? ☐ yes ☐ no
Mother's age when child was born _____
Child's birth weight _____
Delivery was by: ☐ vaginal birth ☐ C-section
Were forceps used? ☐ yes ☐ no
Was delivery difficult? ☐ yes ☐ no
Was it a breech birth? ☐ yes ☐ no

Medical History (continued):

Length of labor _____

Problems with delivery ☐ yes ☐ no

(If yes, please describe; e.g., emergency cesarean section, slow heart rate, fever, cord around neck, etc.)

_____

_____

What were the Apgar scores @ 1 minute_____ 5 minutes _____10 minutes_____

B. Biological Mother's Health During Pregnancy

Did the child's mother experience any of the following during pregnancy?

Bleeding	☐ yes	☐ no
Gained 30 or more pounds	☐ yes	☐ no
Had toxemia or high blood pressure	☐ yes	☐ no
Had to take prescription medications	☐ yes	☐ no

(If yes, name(s) of medication)

_____

Serious injury or illness	☐ yes	☐ no
Alcohol use	☐ yes	☐ no
Drug use	☐ yes	☐ no
Smoked cigarettes	☐ yes	☐ no
Had fever, rash, infection or other illness	☐ yes	☐ no
Had X-Rays	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Other	☐ yes	☐ no

_____

C. Infant's Health at Delivery

Trouble breathing	☐ yes	☐ no
Turned blue (cyanosis)	☐ yes	☐ no
Needed oxygen	☐ yes	☐ no
Turned yellow (jaundice)	☐ yes	☐ no
Required phototherapy	☐ yes	☐ no
Hospitalized after birth more than 7 days	☐ yes	☐ no

Why?_____

Birth defects	☐ yes	☐ no
Jittery	☐ yes	☐ no

Did your child require any special care shortly after birth ☐ yes ☐ no

(If yes, please describe; e.g., blood transfusions, oxygen, incubator, medications, etc.)

_____

_____

D. Health History

In the first month of life did your child experience:

Infections	☐ yes	☐ no
Gagging, choking or vomiting often	☐ yes	☐ no
Difficulty sucking	☐ yes	☐ no

Medical History (continued):

Feeding problems ☐ yes ☐ no

Hospitalizations during the first month of life? ☐ yes ☐ no

If yes to any of the above please explain: _____

_____

_____

Hospitalizations after one month of life:

Date	Reason	Length of Stay

After the first month of life, has your child had any of these medical conditions? **Check if yes**.

Speech problems		Frequent abdominal pain		Serious illness after immunizations	
Eye or vision problems		Frequent or severe headaches		Lead poisoning	
Language problems		Chronic ear infections		Poisoning or overdose	
Hearing difficulties		Pneumonia		Heart or blood pressure problems	
Fine Motor problems (handwriting)		Meningitis		Asthma	
Gross motor problems (clumsiness)		Kidney problems		Seizures ("fits") / Neurologic Problems	
Appetite or feeding problems		Broken bones		Head injury (knocked out)	
Food allergies		Surgery (operations)		Sleeping Problems (too much or too little)	
Other allergies					

If you checked yes to any of the above, please explain below: (i.e., if had surgery please explain what type and age of child) _____

- Is your child taking any medications on a regular basis? ☐ yes ☐ no

Medications Condition the medication is treating

1. _____
2. _____
3. _____
4. _____
5. _____

Developmental History:

- At what age did your child:

Sit without help?		Say single words meaningfully?	
Crawl?		Combine 2 or more words?	
Pull to a stand?		Combine 3 or more words?	
Stand without help?		Use full sentences?	
Cruise (walk holding on)		Use gestures to communicate?	
Walking independently?		Use gestures with words?	
Walk up/down stairs?			
		Show a hand preference?	
		Which hand?	

If your child is 5 years of age and younger:

- **How many words are in your child's vocabulary?** _____
- **How much of what your child hears, does he understand?** _____
- **How many steps in an instructions can your child follow?** _____
- **How much of what your child says, can you understand?** _____
- **How much of what your child says, can others understand?** _____

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

To talk?	☐ yes	☐ no
To understand other people talk?	☐ yes	☐ no
To build with blocks, play with puzzles, draw pictures?	☐ yes	☐ no
Gross motor skills (walking, hopping, riding bicycles, etc)?	☐ yes	☐ no
Fine motor skills (fastening buttons, zippers, drawing, etc)?	☐ yes	☐ no
Early school-related skills (naming colors, alphabet, etc)?	☐ yes	☐ no
To play or socialize with other children?	☐ yes	☐ no

- As an infant, was your child fussy? ☐ yes ☐ no
  Difficult to rouse/over sleepy? ☐ yes ☐ no
  Unresponsive when cuddled? ☐ yes ☐ no

- Has this child had difficulty separating from caregivers? ☐ yes ☐ no
  What age?_____

- Is your child toilet trained? ☐ yes ☐ no
  What age?_____

- Does your child have toileting accidents *during the day*? ☐ yes ☐ no
  How often? _____

- Does your child have any toileting accidents *during the night*? ☐ yes ☐ no
  How often? _____

- Does your child have sleeping difficulties? ☐ yes ☐ no
- (i.e. Difficulty going to bed, falling and/or staying asleep?)
  Please describe:_____

Developmental History (continued):

- Does your child have any eating difficulties? ☐ yes ☐ no
  Please describe: _____
- Does your child have the opportunity to play with same-age children? ☐ yes ☐ no
- What toys or activities does your child seem to enjoy? _____
  _____
  _____
  _____

Educational History:

Did your child attend preschool? ☐ yes ☐ no
Age of
Attendance(s):_____ School:_____
Problems reported in Pre-school: _____

- Did your child attend special needs preschool? ☐ yes ☐ no
  Age of Attendance(s):_____ School:_____
  Please provide a copy of preschool multidisciplinary evaluation.
- Age at Kindergarten entrance: _____School:_____
- Problems reported in Kindergarten:_____
- Has your child ever repeated a grade? ☐ yes ☐ no
  If yes, what grades? _____
- Has your child had a frequent change of schools? ☐ yes ☐ no
  If yes, how many schools has he/she attended? _____
- Current grade placement: _____
- School's name: _____
  _____
- Has your child received or is currently receiving any of the following services:
  Please provide copies of all evaluations that have occurred over the past 5 years such as speech, occupational or physical therapy, psycho-educational, neuropsychological, etc..

			Ages or Grades
Speech/language therapy	☐ yes	☐ no	_____
Physical Therapy	☐ yes	☐ no	_____
Occupational Therapy	☐ yes	☐ no	_____
Learning Disabilities Tutoring	☐ yes	☐ no	_____
Counseling	☐ yes	☐ no	_____

Others, please describe: _____

Educational History (continued):

- Has your child ever been placed in a special educational program?
  Please provide copies of all evaluations.

			Ages or Grades
Developmental Preschool	☐ yes	☐ no	_____
Emotional Handicapped	☐ yes	☐ no	_____
Mental Handicapped/Retardation	☐ yes	☐ no	_____
Learning Disabilities Resource room	☐ yes	☐ no	_____
Multiple Handicapped	☐ yes	☐ no	_____
Hearing Impaired	☐ yes	☐ no	_____
Visually Impaired	☐ yes	☐ no	_____

If your child is 5 years of age and older and in school, please indicate how your child is doing in each of these areas:

	Serious Problem	Below Average	Average	Excellent
Reading				
Spelling				
Math				
Writing				
Behavior				
Athletics				
Attendance				
Turning in assignments				
Social or friends				

If appropriate, is your child involved in any vocational education?

☐ Yes ☐ No ☐ Not Applicable

Difficulties for the Referred Child:

Does your child experience any of the following?

____ Difficulty starting tasks
____ Difficulty completing tasks
____ Impulsivity (acts without thinking)
____ Temper outbursts
____ Low frustration tolerance
____ Difficulty playing quietly
____ Talks excessively
____ Loses things
____ Doesn't listen
____ Engages in dangerous behavior
____ Doesn't learn from experience
____ Poor memory
____ Prefers to play by themselves
____ Poor eye contact
____ Failure to turn when name is called
____ Argues with adults
____ Angry
____ Perfectionistic or particular about certain things

____ Difficulty with changes in routine
____ Difficulty transitioning from one environment to another or one activity to another.
____Sensitivity to sounds (Does your child react negatively to surprising or loud sounds, (i.e.: cries or hides at noise from vacuum cleaner, dog barking, hair dryer?)
____ Does your child have trouble focusing if there is a lot of noise around?
____ Sensitivity to touch (Does your child show signs of distress during grooming, i.e.: fights or cries during hair brushing, face washing, teeth brushing?)
____ Is your child a picky eater (i.e.: will not try new textures, will not eat due to a different smell, etc)?
____ More interested in things vs people
____ Difficulty taking turns
____ Does your child fidget/can't sit still so much that it is interfering with daily routines?
____ Shifts from one uncompleted activity to another
____ Nightmares
____ Temper tantrums (throwing things, screaming, banging head)
____ Overactive or restless; into things more than someone of that age
____ Inattentive; difficulties concentrating, off task
____ Safety concerns (child running out of house/wandering, running into street)
____ Concerns or difficulty with, feeding, dressing self, grooming, etc.
____ Poor relatedness with other family members
____ Seems depressed / Sad
____ Has low self-esteem
____ Easily bored
____ Is anxious/nervous
____ Relevant Pain issues
____ Abuse History (sexual or physical)
____ Been involved in the legal system
____ Difficulty making or keeping friends
____ Acts younger than their age in social situations
Any other concerns not mentioned _____

Has *your child* ever been seen by a psychologist, psychiatrist, or counselor? _____ YES _____ NO
If yes, at what age? _____
For how long were they treated? _____

Please indicate whether your child has ever been diagnosed with any of the following conditions, approximately what age they were diagnosed, and what type of professional made the diagnosis (i.e. pediatrician, psychiatrist, etc).

- ADD, AD/HD ☐ yes ☐ no Age at diagnosis_____ By whom_____
- Learning disability ☐ yes ☐ no Age at diagnosis_____ By whom_____
- Depression ☐ yes ☐ no Age at diagnosis_____ By whom_____
- Anxiety ☐ yes ☐ no Age at diagnosis_____ By whom_____
- Autism/ Asperger's ☐ yes ☐ no Age at diagnosis_____ By whom_____
- Other Mental Health ☐ yes ☐ no Age at diagnosis_____ By whom_____

Please specify which_____

Discipline:

Please check below the types of discipline used at home for your child's behavior:

Time out	____	Talking it out	____
Taking things away	____	Yelling	____
Spanking	____	Ignoring	____
Grounding	____	Extra Chores	____
Praise/reward good behavior	____		

Please comment on the effectiveness of the methods you use: _____

_____

_____

What do you enjoy most about raising your child:_____

_____

_____

_____

What do you find the most difficult about raising this child: _____

_____

_____

_____

Additional Information

Please add any additional information that you believe will help us to better understand your child.

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form. Please send this back along with any additional paperwork and reports, including previous evaluations, IEP, etc. We are looking forward to meeting with you and your child in our Developmental-Behavioral Pediatrics Clinic!