DIRKSEN CENTER

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PROFESSIONAL CONSULTING • CLINICAL ASSESSMENT • EDUCATIONAL MAPPING

Pediatric Questionnaire

By completing this questionnaire prior to your appointment, you will be helping us to better understand your questions and the concerns that are affecting your child and your family. This will also provide us with a great deal of important information, which will allow us to work with you more effectively. Please answer these questions as completely as possible, and bring this form with you to your initial appointment.

Child's name: ______________________________ Nickname: __________________

Date of birth: ________ Age of child: _______ Sex: ______________________

Handedness: ________________

Parent(s) name(s): ____

Address: ____

Telephone: Home ___________________________ Work ___________________________

Name of person completing form: ______________________________

Relationship to child: ______________________________

Date form completed: ______________________________

Are you this child's legal guardian? ___ Yes ___ No

PLEASE ATTACH YOUR CHILD'S MOST RECENT SCHOOL PHOTO HERE.

If you are not the guardian, do you have written consent documenting your right to seek treatment for this child?
___Yes ___ No

I. Purpose of Evaluation

Who suggested you get this evaluation?

Please describe the problems that are affecting your child and your family:

When did you first become aware of these problems?

What seems to help the problems?

What seems to make the problems worse?

Has your child received evaluation or treatment for these problems before? If yes, when and with whom?

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

What do you consider to be your child's best qualities or strengths?

II. Birth History

This section is to be completed by the child's mother, if possible.
(If this child is an adopted/foster child, please complete according to your knowledge of birthmother and pregnancy history)

Please indicate the following:
Number of pregnancies you have had: _____
Number of live births _____
Number of stillbirths _____
Number of miscarriages _____

Number of living children _____
Number of deceased children _____
This child was the product of pregnancy number _____

	Yes	*No*
Did you receive regular medical care during this pregnancy?	_____	_____
Did you have any problems during the pregnancy?	_____	_____

If yes, please describe the problem and the time it occurred during the pregnancy (such as diabetes, excessive vomiting, bleeding, high blood pressure, toxemia, weight loss, fever, accidents): ____________________

____

If yes, did you require hospitalization or were you placed on bed rest?	_____	_____

Please explain:
____

____

Did you smoke cigarettes during this pregnancy?	_____	_____

If yes, how many packs a day did you smoke? _____

Did you consume alcoholic beverages during this pregnancy?	_____	_____

If yes, how many days per week, on average, did you drink? ____
If yes, how many ounces per week, on average, did you drink? ____

Did you take medication during this pregnancy?	_____	_____

If yes, please list:
1)
2)
3)

Did you carry this baby a full 9 months?	_____	_____

If no, please indicate length of pregnancy in weeks:______

How long did labor last in hours? _______

What was the child's birth weight?_______

	Yes	No
Were there any problems with the delivery?	_____	_____

If yes, please describe the problems (e.g., emergency Cesarean section, slow heart rate, fever, cord around neck, etc.). ____

____

Apgar scores (if known): 1 minute:_____ 5 minutes: _____

	Yes	No
Did your baby require any special care shortly after birth?	_____	_____

If yes, please describe the type of care (e.g., phototherapy, blood transfusions, oxygen, incubator, medications, etc.)
____

____

How long after birth was the baby taken home? _____________________

III. Medical History

When was your child's most recent physical?______________

	Yes	No
Were there any medical concerns at this time (if yes, please describe) ____________________________________	_____	_____

____

	Yes	No
Has your child ever been hospitalized?	_____	_____

If yes, please list ages and reasons:__________________
____
____

	Yes	No
Has your child ever had surgery?	_____	_____

If yes, please list ages and reasons: __________________
____
____

	Yes	No
Has your child had any serious accidents?	_____	_____

If yes, please describe, including ages: _______________
____
____

	Yes	No
Has your child ever had a seizure or convulsion?	_____	_____

If yes, please describe, including ages and medications that were prescribed, if any: _______________________
____
____

	Yes	No
If yes, was the seizure or convulsion associated with a high fever?	_____	_____

	Yes	No
Has your child had any head injuries?	_____	_____
If yes, what happened and when? ____________________		
____		
____		
Was the child unconscious?	_____	_____
Was the child dizzy?	_____	_____
Did the child have a headache afterward?	_____	_____
Did the child vomit afterward?	_____	_____
Does your child have any allergies?	_____	_____
If yes, please describe: ____________________		
Does your child have frequent abdominal pains or vomiting?	_____	_____
If yes, when does this occur? ____________________		
Does your child have frequent or severe headaches?	_____	_____
If yes, how are these treated? ____________________		
Does your child have any other chronic physical complaints?	_____	_____
Please specify: ____________________		
Does your child wear glasses/have any vision problems?	_____	_____
Please specify: ____________________		
Does your child need hearing aids/have any hearing problems?_____	_____	
Please specify: ____________________		
Has your child ever had a hearing exam?	_____	_____
If yes, when? ____________________		
What were the findings? ____________________		
Does child have a history of frequent ear infections?	_____	_____
If yes, please specify how often and at what ages: _____		
____		
If yes, please specify how they were treated (P.E. tubes, antibiotics):____________________		
Is your child taking any medications on a regular basis?	_____	_____
If yes, please list the medications and reasons child is taking them: ____________________		
____		
Has your child taken any other medications in the past?	_____	_____
If yes, please list the medications and reasons child took them: ____________________		
____		

Please list the name, address, and telephone number of the doctor (e.g., pediatrician, family physician) who cares for your child:

Name: ________________________________
Address: ________________________________
____
____
Telephone number: ________________________________

IV. Developmental History

At what age did your child...
(if you are unsure, please estimate)

Roll over	_____	Say single words meaningfully?	_____
Sit without help?	_____	Combine 2 or more words?	_____
Walk without help?	_____	Use sentences?	_____

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

	Yes	***No***
To talk?	_____	_____
To understand?	_____	_____
To build with blocks, play with puzzles, draw pictures?	_____	_____
Gross motor skills (walking, hopping, riding bicycle, etc.)?	_____	_____
Fine motor skills (fastening buttons, zippers, drawing, etc.)?	_____	_____
Early school-related skills (naming colors, saying alphabet)?	_____	_____
To sit still for TV or stories?	_____	_____
Staying with any one activity for a reasonable time?	_____	_____
To play or socialize with other children?	_____	_____

Does your child have or ever had (check all that apply)?

Poor handwriting?	_____	Toe walking?	_____	Loss of skills?	_____
Blank spells?	_____	Falling spells?	_____		
Tics or twitching?	_____	Clumsiness	_____		

If yes, please clarify:__________________________

As an infant, did your child demonstrate a:

_____High activity level (e.g., overactivity)

_____Age-appropriate activity level

_____Low activity level (e.g., lethargic)

	Yes	***No***
Has this child had difficulty separating? If yes, at what age: _____	_____	_____
Did your child have any difficulties with early bonding?	_____	_____
Is your child toilet trained? If yes, at what age: _____	_____	_____
Does your child have toileting accidents during the day? If yes, how often: ____________________________	_____	_____

	Yes	*No*
Does your child have toileting accidents at night?	_____	_____
If yes, how often: ______________________________		
Has your child had any sleeping difficulties?	_____	_____
If yes, please describe: _________________________ ____		
Has your child had any eating difficulties?	_____	_____
If yes, please describe: _________________________ ____		
Has your child had angry outbursts, temper tantrums, or other behaviors that caused you concern? Describe: _________ ____ ____	_____	_____
Does your child have the opportunity to play with same-age children?	_____	_____

Does your child prefer to play with older, younger or same-age children? ____________________________

How does your child occupy him/herself? What toys or activities does your child seem to enjoy?
____

____

How does the child respond to discipline? ____

____

Has discipline been frequently necessary? ____

____

Who ordinarily disciplines the child? ____

____

V. Family History

Mother/Parent's name: ____ Age: _____________

Highest level of education completed: __________ Occupation: ______________________________

Place of employment: ____

Work hours: _________________________________ Work phone: ______________________________

Father/Parent's name: ____ Age: _____________

Highest level of education completed: __________ Occupation: ______________________________

Place of employment: ____

Work hours: _________________________________ Work phone: ______________________________

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

Highest level of education completed: _________ Occupation: ____________________________

Place of employment: ____

Work hours: _______________________________ Work phone: ____________________________

Parents are:

Married: _______Date:
Separated: _______Date:
Divorced: _______Date:
Unmarried: _______Date:
Widowed: _______Date:

If parents are divorced, who has legal custody? ___________________________

If parents are separated or divorced, please describe physical custody and visitation arrangements?

____

____

Please list the persons who are currently living in the home with the child:

Name	Sex	Age	Relationship to child

Please list any family members who are no longer at home:

Name	Sex	Age	Relationship to child	When did they leave?

Is this child a foster child? Yes _____ No _____ Is this child adopted? Yes _____ No _____

If a foster child or adopted, at what age was the child placed with you? ______________

If a foster child or adopted, has this been discussed with the child? Yes _____ No _____

If adopted, when was adoption legally finalized? ___________________________________

If a foster child or adopted, how many placements occurred prior to being placed in your home?

____

If there have been previous placements, please list all of the child's placements and length of placement____

How long has the child been living in the current home or apartment? ______________________

How many times has your child been moved during the past 3 years? ______________________

Who provides care for your child while you are at work (if applicable)? ______________________

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

	Yes	***No***
Death of a family member:	_____	_____
Serious illness:	_____	_____
Unemployment:	_____	_____
Marital problems:	_____	_____
Other (please describe _________________________	_____	_____

Has your child ever lost any person with whom he/she seemed to have a close relationship, such as a relative, caretaker, etc.? _____ _____

If yes, at what age(s)?_________________________________

Who?____

Has your child or family ever been seen by a psychologist, psychiatrist, or counselor? _____ _____

If yes, please describe: _______________________________

____

____

Please list anyone in the family who is left-handed or "mixed-handed:" ______________________

____

Please indicate if anyone in the patient's immediate or extended family (parent, grandparent, brother/sister, uncle/aunt) has had any of the following?

(if you need more room, please add more comments below this section)

	Yes	Who?	Explain
Learning problem (e.g., reading, math)	____	___________________	_______________________
		___________________	_______________________
Language difficulties	____	___________________	_______________________
Hyperactivity (or "ADHD")	____	___________________	_______________________
Psychiatric problems (e.g., depression, anxiety, "nervous breakdown")	____	___________________	_______________________
		___________________	_______________________
		___________________	_______________________
Substance use problems (including alcohol)	____	___________________	_______________________
		___________________	_______________________
Seizures/Epilepsy?	____	___________________	_______________________
Neurological disease?	____	___________________	_______________________
Mental Retardation?	____	___________________	_______________________
Any genetic disorders?	____	___________________	_______________________

VI. School History

	Yes	*No*
Did your child attend preschool?	_____	_____

If yes, give ages of attendance: __________________
Preschool name: ______________________________

Age at kindergarten entrance: _____________________

Age at first grade entrance: ________________________

Has your child ever repeated a grade?	_____	_____

If yes, which grade(s): ________________________

Has your child been evaluated or tested before?	_____	_____

If yes, when and by whom? ____________________

____

Has this child had a frequent change of schools?	_____	_____

How many schools has he/she attended? _________

Current grade placement: __________________________

School name: ________________________________

Address: ____________________________________
(street)

____
(city) (state) (zip code)

Has school reported current problems with: (Check)

Reading	_____	Describe:________________________________
Spelling	_____	Describe:________________________________
Writing	_____	Describe:________________________________
Arithmetic	_____	Describe:________________________________
Social adjustment	_____	Describe:________________________________
Attention span	_____	Describe:________________________________
Following directions	_____	Describe:________________________________

Has your child received any of the following services?

	Yes	*No*	*Ages or Grades*
Speech/language therapy	____	____	______________
Physical therapy	____	____	______________
Occupational therapy	____	____	______________
Learning disabilities tutoring	____	____	______________
Counseling	____	____	______________
Other (please describe: __________________)	____	____	______________

Has your child ever been placed in any of the following special educational programs?

	Yes	*No*	*Ages or Grades*
Developmental/transitional	____	____	______________
Emotional handicapped	____	____	______________
Mild mental handicapped/retardation	____	____	______________
Moderate mental handicap/retardation	____	____	______________
Severe/profound mental handicap/retardation	____	____	______________
Learning disabilities resource room	____	____	______________
Multiple handicapped	____	____	______________
Hearing impaired	____	____	______________
Visually impaired	____	____	______________
Have you requested an evaluation through your school?	____	____	______________

Thank you for taking the time to complete this questionnaire. I look forward to seeing you on your appointment date.

____
(signature of parent/guardian)

____
(today's date)

____
(city, state, zip code)

____
(telephone number)