

# Lucile Salter Packard Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER  
725 Welch Road Palo Alto, CA 94304



CLINIC VISITS • DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS •  
DEVELOPMENTAL INATAKE QUESTIONNAIRE

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Medical Record Number

Patient Name

Addressograph or Label

Name of person completing form: \_\_\_\_\_

Date form completed: \_\_\_/\_\_\_/\_\_\_

*Office Use Only*

Date DBP Received Quest: \_\_\_/\_\_\_/\_\_\_

Medical Record #: \_\_\_\_\_

## I. GENERAL INFORMATION

<b>CHILD'S NAME:</b>	<b>Last Name:</b>	<b>First Name:</b>	
<b>Date of birth:</b>	___/___/___	<input type="checkbox"/> <b>Male</b>	<input type="checkbox"/> <b>Female</b>
<b>Mother's name / date of birth:</b>			___/___/___
<b>Father's name / date of birth:</b>			___/___/___
<b>Home address:</b>			
<b>Home phone &amp; alternate phone #s:</b>			
<b>Second home address &amp; phone # (specify parent):</b>			
<b>Child's primary language:</b>			
<b>Parents' primary language:</b>			

<b>Child's primary doctor:</b>	
<b>Primary doctor's address and telephone number:</b>	
<b>Other involved physicians:</b>	
<b>Other involved service providers:</b>	

<b>PRIMARY MEDICAL INSURANCE NAME:</b>	
<b>Address and telephone number (for us to contact for legibility):</b>	
<b>Name of Insured (father or mother):</b>	
<b>Policy ID Number:</b>	
<b>Group Number:</b>	
<b>Employer Name &amp; City:</b>	
<b>SECONDARY MEDICAL INSURANCE NAME:</b>	

<b>CURRENT PROGRAM OR SCHOOL:</b>	
<b>Address and telephone number:</b>	
<b>Program/School Phone Number:</b>	
<b>Contact Person and phone #:</b>	

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**II. CONCERNS**

**What do you hope to accomplish during this visit?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Main Concern:** Please describe

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

At what age did this problem first appear? \_\_\_\_\_

What have you done about this problem to date? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Additional Concern 2:** Please describe

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

At what age did this problem first appear? \_\_\_\_\_

What have you done about this problem to date? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Additional Concern 3:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

At what age did this problem first appear? \_\_\_\_\_ What have you done about this problem to date? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**III. CURRENT FUNCTIONING**

What are your child's interests or favorite activities?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your child's strengths?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe your child's abilities to:

Learn and use information, such as letters and numbers?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Handle various tasks and demands, including stressful or frustrating situations?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Communicate, verbally, non-verbally, and in writing?

Move about and manipulate objects?

Take care of him / herself, including eating, toileting, dressing, and getting to sleep?

Relate to others, including strangers, friends, peers, family members, and other adults?

Engage in Play?

Participate in community and social life, including play groups, classes or programs?

**IV. MEDICAL INFORMATION**

**A. Pregnancy, Labor, and Delivery History** (for child's mother to complete)

How many times have you been pregnant? \_\_\_\_\_ How many children do you have? \_\_\_\_\_  
Birth order of this child? \_\_\_\_\_ How old were you when this child was born? \_\_\_\_\_

Were you healthy during the pregnancy of this child?  Yes  No

If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

Were there medical or other problems during the pregnancy or delivery ( fertility treatment,  procedures required,  infections,  unusual exposures)?

If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

Did you have any of the following tests ( ultrasounds,  amniocentesis,  CVS,  other) during the pregnancy? Were any of them abnormal?

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Did you take  prescription medications,  herbal remedies, or  over the counter medications in pregnancy?

Which ones?: \_\_\_\_\_  
\_\_\_\_\_

**B. Birth History**

Name of the hospital child was born at: \_\_\_\_\_ City: \_\_\_\_\_

Was the baby premature?  Yes  No If so, \_\_\_\_\_ weeks gestation at birth

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What was the mode of delivery?  Vaginal  Cesarean Section. Were there problems?  No  Yes

If yes, describe \_\_\_\_\_

Birth weight? \_\_\_\_\_ Appgars (if known)? \_\_\_\_\_

Did your child go to the special care nursery or NICU?  Yes  No. If so, why? \_\_\_\_\_Did your child have any problems in the first few days of life?  Yes  No. If yes, describe. \_\_\_\_\_Did your child have feeding problems as a newborn or infant?  Yes  No. If yes, describe. \_\_\_\_\_

How long did your child stay in hospital before going home? \_\_\_\_\_

**C. Medical History**

Please answer the following questions about your child's medical history.

Has your child ever:	Date:	Reason and/or Results
Been to the emergency department?		
Been hospitalized?		
Had surgery?		
Had any serious accidents?		
Had any chronic medical concerns?		
Had any allergies (food, medicine, airborne, etc.)		
Had genetic testing?		
Been to a neurologist?		
Had an MRI or CT scan?		
Had an EEG?		
Had a hearing test?		
Had his/her vision tested?		
Had any other medical tests?		

Are your child's immunizations up to date?  Yes  No**D. Medication History**

Does your child take:	Current or past?	Which ones and why?
Prescription medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Prescribed by:
Over the counter medications (including vitamins)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other biomedical/complementary / alternative treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No		Supervised by:

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**V. FAMILY AND SOCIAL HISTORY**Who lives in the home? \_\_\_\_\_  
\_\_\_\_\_Is your child adopted?  Yes  No Are parents divorced?  Yes  No Are parents separated?  Yes  No

Family Member	Age	Education level/ Grade in School	Occupation
Mother			
Father			
Sibling 1			
Sibling 2			
Sibling 3			
Other			
Other			

Do any illnesses or conditions run in the family?  Yes  No If so, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does anyone in your immediate or extended family have/or had any of the following problems?

	Family Member
Learning problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Attention Deficit Hyperactivity Disorder (ADHD)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression, mental illness, anxiety, or other difficulties with their nerves? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems with muscles? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language problems or talked late? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Intellectual Disability/ Global Developmental Delay/ Mental Retardation <input type="checkbox"/> Yes <input type="checkbox"/> No	
Autism or a Pervasive Developmental Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**VI. REVIEW OF SYSTEMS**

Please circle any of the following problems that your child may have:

General Health, energy, tiredness	Heart
Eyes / vision	Stomach / digestion
Ears / hearing	Stooling (constipation or diarrhea)
Snoring	Kidney / Urination (peeing)
Mouth / teeth	Muscles or bones
Swallowing / feeding	Head injury / seizures
Breathing	Birthmarks, freckles under arms or in the groin
Allergies	Hormones
Blood / sickle cell	Mental Health

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**VII. DEVELOPMENTAL HISTORY**

At what age did you become concerned with your child's development? \_\_\_\_\_

What concerned you at that time? \_\_\_\_\_

Has your child ever lost skills?  Yes  No. If yes, when and what skills. \_\_\_\_\_

Does your child prefer to use his/her (circle one):  Right hand  Left hand  Both

Please give us information on the following milestones:

	When did your child begin to (best memory is okay)	Comments
Sitting independently		
Walking		
Waving "bye-bye"		
Pointing/Showing objects to others		
First word		
2-word combination		
Pretend/imaginary play		
Toilet trained in daytime		
Writes Name, letters and colors		
Shows interest in counting		

**VIII. PRESCHOOL/SCHOOL HISTORY:**

Please list past preschools & schools attended:

School name:	Dates (start-end):	Age:	Type of setting:
EXAMPLE: Rainbow Preschool	From June 2005-June 2006	Ages 12-24 months	Community co-op preschool

Current grade: \_\_\_\_\_ Type of class:  Regular classroom  Special classroom

Number of children in classroom: \_\_\_\_\_ Number of teachers in classroom: \_\_\_\_\_

**IX. PREVIOUS EVALUATION AND SERVICE HISTORY**

Please list below any testing done with a psychologist, speech and language pathologist, or other therapist.

Test Done	With Whom	Where	When

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Please indicate any services your child receives or has received in the past.

Service Type	Dates of Service	Service Provider (if known)
Early Intervention / IFSP		
Social Worker / Case Manager		
Speech and Language Therapy		
Occupational Therapy		
Physical Therapy		
Behavior Support Plan		
Applied Behavior Analysis		
Special Education / IEP		
Mental Health Services		
Public Health Services		
Learning Support (Tutor/Resource Specialist)		List subject area:
Other Services		Please list:

Is / was your child qualified for services with the Regional Center?  Yes  No

Is / was your child qualified for Medical Therapy Program with CCS  Yes  No

Comments about your child's educational and/or intervention program: \_\_\_\_\_

Is there anything else you would like to share with us? \_\_\_\_\_

**Dear parent,**

**Thank you for completing the Questionnaire. We would like to recommend that you please:**

- Keep a copy for your records**
- Contact your medical insurance company upon receipt of the Questionnaire to confirm whether or not an authorization for developmental assessment is needed**
- Very important: If you have legal guardianship for this child, please include the legal documentation**

**We look forward to seeing you soon,**

**DBP Program**

Date: \_\_\_\_\_

**SIGNATURE** (Patient, Parent or Properly Designated Representative)

**PRINT NAME OF SIGNATOR :** \_\_\_\_\_ **RELATIONSHIP to Patient** \_\_\_\_\_

DATE	TIME	Reviewed by (Signature):
		PRINT Name: _____ Credentials _____ Pager Number, if applicable _____