Stony Brook University Hospital Department of Pediatrics
Developmental and Behavioral Pediatrics Intake Questionnaire

Today's Date:_____

Child's name:_____ Sex: M F

Date of birth:_____ Age:_____ years _____months

Primary language(s) spoken in home: _____ Preferred language? _____

Will you like/need the services of an interpreter during your appointments? ☐ Yes ☐ No

Person completing this form:_____ Relationship to child:_____

Child's Health Care Provider:_____

Provider's address & phone number:_____

*Please answer the following questions as well as you can.

Is child ☐ adopted ☐ in foster care If so, from what age? _____

Who referred you for an evaluation? _____

What are your concerns about your child?

☐ Language/speech ☐ Cognitive/learning development ☐ Emotional development

☐ Motor development ☐ Behavior problems ☐ School performance

☐ other: _____

Please explain: _____

_____

_____

At what age did you first become concerned? _____

What first caused you to be concerned? _____

_____

What questions do you have for the doctor about your child?

_____

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Has the child stopped developing and learning or lost any skills? ☐ Yes ☐ No

If Yes, what skills? _____

Has your child been diagnosed with any medical or developmental conditions? ☐ Yes ☐ No

If yes, please complete:

Condition	Date of Diagnosis	Given by whom

***If you need more room, please use other side of this page.

What would you like to happen or accomplish during this evaluation? _____

_____

_____

Does your child receive any of the following services?

Service		When did it start? How often per week or month?	Who provides services
Occupational Therapy	☐ Yes ☐ No		
Physical Therapy	☐ Yes ☐ No		
Speech Therapy	☐ Yes ☐ No		
Behavioral Therapy	☐ Yes ☐ No		
Feeding therapy	☐ Yes ☐ No		
Early intervention/IU	☐ Yes ☐ No		
Other:			

Prenatal History

- How old was mother when she became pregnant? _____
- Was the pregnancy ☐ Planned ☐ Planned, w/ preconception counseling/education ☐ Unplanned ☐ Don't know
- When did the mother start prenatal care? _____

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- During the pregnancy, mother had:
  - ☐ High blood pressure ☐ Diabetes ☐ Venereal disease ☐ Measles
  - ☐ Smoked cigarettes (amount per day)_____ per day
  - ☐ Used drugs/alcohol (amount per day) _____
  - ☐ Caffeine use ☐ Protein in urine ☐ poor weight gain ☐ Child was very active in womb
  - ☐ Mother took medications-(explain)_____
  - ☐ Stress during pregnancy-(explain)_____
  - ☐ Abnormal ultrasound-(explain)_____
  - ☐ Abnormal tests during pregnancy-(explain)_____
  - ☐ Other pregnancy problems-(explain)_____

Birth History

- Was the delivery: ☐ Vaginal ☐ C-section ☐ Forceps ☐ Vacuum used ☐ Breech
  ☐ Pitocin was used ☐ Antibiotics given during labor
- Were there any complications? ☐ Yes ☐ No If yes, explain:_____
- Was the baby full term? ☐ Yes ☐ No If no, ☐early ☐late by _____ weeks
- How long was mother in labor? _____ induced: ☐ Yes ☐ No ☐ Unknown
- Baby was: ☐ breast fed ☐ bottle fed ☐ both
- Were there any of the following problems in the nursery? Please explain if checked
  - ☐ Was in NICU _____
  - ☐ Breathing problems _____
  - ☐ Low oxygen _____
  - ☐ Infection _____
  - ☐ Needed ventilator _____
  - ☐ Feeding/sucking problems _____
  - ☐ Tube feedings _____
  - ☐ Jaundice _____

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- ☐ Needed light therapy _____
- ☐ Apnea _____
- ☐ GER (reflux) _____
- ☐ Blood problems _____
- ☐ Intraventricular hemorrhage (bleeding in brain) _____
- ☐ Other: _____

- Baby's birth weight: _____lbs, _____oz Baby's length at birth: _____ inches
- Medications given to baby: ☐ Yes ☐ No If yes, explain:_____

Infancy History (under 1 year of age)

- Overall child was ☐ easy ☐ difficult ☐ a lot of work
- Describe the following issues of the baby

	Normal	Abnormal	Explain
o Sleeping	☐	☐	_____
o Crying	☐	☐	_____
o Eye contact	☐	☐	_____
o Cooing/babbling	☐	☐	_____
o Activity	☐	☐	_____
o Sociable	☐	☐	_____
o Playful	☐	☐	_____

Review of Systems	Normal	Abnormal	Comments
• Head, eyes, ears, nose, throat			_____
• Vision Screening (date:_____)			_____
• Hearing screening (date: _____)			_____
• Heart			_____

- Lungs _____
- Stomach/Intestinal/Constipation _____
- Skin _____
- Sleeping/Snoring _____
- Muscles/joints/bones _____
- Neurological (nervous system) _____
- Endocrine _____
- Environmental (exposure to smoke/toxins) _____
- Nutrition/Diet _____

Please list a typical day's diet and eating times for this child:

Breakfast Time:	Lunch Time:	Dinner Time:	Snacks Times:

- Bowel Movements Formed Loose Diarrhea Constipated

  other: _____

- Are your child's immunizations up to date? ☐ Yes ☐ No

Medical History

- **Please check any of your child's current medical diagnosis or conditions/problems from the following list:** Please explain if checked
  - ☐ Gastroesophageal reflux _____
  - ☐ Failure to thrive/slow growth _____
  - ☐ Asthma _____
  - ☐ Low muscle tone/weakness _____

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- ☐ Feeding issues/GI problems _____
- ☐ Heart problems or diagnoses _____
- ☐ Cerebral palsy _____
- ☐ Eczema _____
- ☐ Seizures _____
- ☐ Other (specify) _____

- **Please list any medications your child is currently taking (including vitamin supplements**) ☐ None

Medication	Dose	Frequency

- **Does your child have any allergies?** ☐ Yes ☐ No If yes, what are they? _____

- **Has your child ever been hospitalized or required surgery?** ☐ Yes ☐ No
  If yes, please complete:

Date	Reason

- **Does your child see any specialists?** ☐ Yes ☐ No
  If yes, please complete:

Name of specialist	Specialty	Last seen

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- Have any of the following medical tests been done?

☐ Upper GI series ☐ Endoscopy ☐ Genetic (chromosome) testing
☐ Head CT scan ☐ Head MRI ☐ EEG
☐ Other: _____

Were these tests done at Stony Brook? ☐ Yes ☐ No

****If no, please send copies of reports with intake packet**

<u>Developmental History</u> (please estimate if exact ages are unknown or you do not know)

Gross Motor

Milestone	Age	Not Applicable	Milestone	Age	Not Applicable
Roll over	_____		Climbs stairs (1ft per step)	_____	
Sits unsupported	_____		Run	_____	
Crawls	_____		Pedal tricycle	_____	
Pulls to stand	_____		Hop	_____	
Walk around furniture	_____		Ride a 2-wheeler	_____	
Walks alone	_____		Tie shoes	_____	
Climbs stairs (2ft per step)	_____				

Fine Motor/Adaptive

Milestone	Age	n/a	Milestone	Age	n/a
Opens hands	_____		Removes some clothes	_____	
Reach for objects	_____		Zippers and snaps	_____	
Feed self w/ fingers	_____		Unbutton clothes	_____	
Pincer grasp	_____		Buttons clothes	_____	
Hold cup	_____		Spread w/ knife	_____	
Uses spoon (w/out help)	_____		Cut w/ knife and fork	_____	
Shows hand preference	_____	(Right Left)			

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Language

Milestone	Age	n/a	Milestone	Age	n/a
Smile to others	_____		Follow simple command (given gesture)	_____	
Coo	_____		Follow simple command (w/out gesture)	_____	
Laugh	_____		Says 4-6 words	_____	
Babble	_____		Makes 2-word phrases	_____	
Wave bye-bye	_____		Says 50 words	_____	
Say mama/dada	_____		States his/her name	_____	
Understand "no"	_____		Uses complete sentences	_____	
Say first word	_____		Tells fibs	_____	
Point to desired object	_____		Holds conversations	_____	
Prints his/her name	_____		Loss of language	_____	

- How much of your child's speech can a stranger understand?

  Less than half About half Three quarters All or almost all

- Toilet Trained:
  - Urine: Daytime ☐ Yes ☐ No At night: ☐ Yes ☐ No
  - Stool: Daytime ☐ Yes ☐ No At night: ☐ Yes ☐ No

- How old does your child act? _____

Behavioral History

- Activity level of child Normal High Low
- Emotionality Happy Angry Moody Depressed other: _____
- Sociability with other children Ignores children Observes them Parallel play

  Initiates play Joins play Intrudes on play Prefers adult interaction

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- What does your child like to do for play? _____

  _____

- Does your child have difficulty with any of the following (currently or past)
  (if checked please describe below)

  ☐ Colic ☐ Irritability ☐ Sleeping ☐ Eating ☐ Eating non-food items

  ☐ Tantrums ☐ Head banging ☐ Hitting self ☐ Hitting others ☐ Biting

  ☐ Impulsivity ☐ Hyperactivity ☐ Short attention span ☐ Forgetfulness

  ☐ Difficulty completing tasks ☐ Lack of concentration ☐ Distractibility

  ☐ Lying ☐ Stealing ☐ Trouble with peers ☐ Trouble with siblings

  ☐ Fighting ☐ Destructiveness ☐ Fire setting ☐ Obsessions

  ☐ Compulsions ☐ Rituals ☐ Transitions ☐ Unusual interests

  ☐ Need for sameness ☐ Self-stimulation ☐ Unusual body movements

  Explain: _____

  _____

  _____

  _____

- Are problems more at: ☐ Home ☐ School other: _____
- How do you deal with these behaviors

  ☐ Ignoring ☐ Lecturing/Explaining ☐ Scolding ☐ Spanking

  ☐ Send child to his/her room ☐ Removal of privileges

  ☐ other: _____

Educational History

- Does your child have problems in school? ☐ Yes ☐ No If yes, explain _____
- Has your child received special education or other help in school? ☐ Yes ☐ No
  If yes, explain _____
- Has your child ever repeated a grade? ☐ Yes ☐ No If yes, why _____

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- Please list all schools or education programs your child has attended

Year	Child's age	School	Grade or type of program

- Please list all previous evaluations of behavior or development of your child

Date	Type of professional	Location	What you were told about the results

****Please send copies of these evaluations, or ask the person who performed these evaluations to send us a copy to**

Developmental Pediatrics
5 Medical Drive
Port Jefferson Station, NY 11776
Att: Laurie Quaies

Family History

	Name	Age	Highest grade completed	Occupation
• Child's Father	_____	_____	_____	_____
• Child's Mother	_____	_____	_____	_____

Is there anyone in the family with any of the following? (tell us who in relation to the child has these conditions)

Condition	Father's side	Mother's side	Sibling	Details/Treatment
ADD				
ADHD				
Learning Disabilities				
Other learning problems				
Special Education				
Autism/PDD/Aspergers				
Birth Defects				
Cerebral Palsy				
Delayed speech				
Mental Retardation				
Seizures				
Other developmental problems				
Behavior problems				
Depression				
Bipolar/Manic depressive				
Suicide				
Obsessive compulsive disorder				
Tics/Tourettes				
Excessive anxiety				
Medication for mental health				
Other mental health problems				
Thyroid disorders				
Muscular Dystrophy				
Substance abuse				

Social History

- Who lives at home with the child? _____
- Who takes care of child when not in school? ☐ Parent ☐ Grandparent ☐ Other relative
  ☐ Nanny ☐ Daycare/childcare provider –Name _____
    - If in daycare, since what age? _____
    - How many hours per week on average? _____

- How much time does child spend watching TV or videos? _____
- What is your child's favorite TV, book, movie character? _____
- Any sports/social activity involvement? ☐ Yes ☐ No
  - If yes, what? _____

- Is the child's life affected by any of the following? (Please check and explain all that apply)
  ☐ Separation/divorce, relationship problems _____
  ☐ Custody issues _____
  ☐ Grief/loss issues _____
  ☐ Work/school problems _____
  ☐ Social skills or peer problems _____
  ☐ Legal problems _____
  ☐ Physical challenges _____
  ☐ Financial problems _____

Anything else you would like us to know?

_____

_____

_____

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