Patient Name:
Patient DOB:

PARENT/GUARDIAN Questionnaire for New Patients

Elliot Developmental Pediatrics

The attached questionnaire is an opportunity for you to share information with us about your child before his or her evaluation. This will help us know about your child's health and the treatments your child is receiving. The questionnaire should be filled in by the person who takes care of the child most of the time.

These questionnaires are designed so you can fill them in yourself. There is no right or wrong answer. Answer each question to the best of your ability. Please also add any additional comments or any health problems that were not covered by the questions.

The questionnaire will be reviewed by staff at Elliot Developmental Pediatrics who will be involved in your child's evaluation.

Please call if you have to any questions you or difficulty filling out this form.
Phone: 603-663-3222

Please note that all information is kept strictly confidential.

Once you have completed this form, please send it to:
Elliot Developmental Pediatrics
275 Mammoth Rd
Manchester, NH 03109

Or fax to: 603-663-3229

Patient Name:
Patient DOB:

Patient Name:
Patient DOB:

Elliot Developmental and Behavioral Pediatrics

Date: _____

Person completing this form: _____ Relationship to Child: _____

Child's Name: _____ Date of Birth _____ Age _____ Sex _____

Home Address: _____

Home Phone: _____

Please state your main concerns about this child:

_____

_____

_____

_____

Who Referred You Here? Name _____ Phone_____

Address _____

Reason for the referral: _____

_____

Has anyone else diagnosed this child with any developmental disabilities? Please list specialists and diagnoses:

_____

_____

_____

_____

Name of School or Early Supports and Services Agency: _____

Contact Person: _____ Phone: _____

Grade if in School: _____Is there an IEP? _____ What is the Primary Disability/Coding ?_____

_____

Does this child receive any special education services? Describe: _____

_____

_____

Other's involved in this child's care (mental health, speech, OT, PT, therapies, etc). Please list agency and provider:

Please send reports of any evaluations <u>prior to</u> the visit

_____

_____

_____

Patient Name:
Patient DOB:

The Child's Interests and Accomplishments:

What are your child's main hobbies and interests? _____

_____

What are your child's areas of greatest accomplishments? _____

_____

What does your child enjoy doing most? _____

_____

What does your child dislike doing most? _____

_____

What do you like about your child? _____

_____

CURRENT HOUSEHOLD:

Is this Child: Adopted? _____ (age of child at adoption _____)

In Foster Care? _____ (age of child when entered foster care _____)

Parents are: _____ Married _____ Never married _____ Divorced (age of child at divorce _____)

Who lives in the primary household with this child?

Name: _____ AGE: _____Relationship to child: _____

Name: _____ AGE: _____ Relationship to child: _____

Name: _____ AGE: _____ Relationship to child: _____

Name: _____ AGE: _____ Relationship to child: _____

Name: _____ AGE: _____ Relationship to child: _____

Name: _____ AGE: _____ Relationship to child: _____

Name: _____ AGE: _____ Relationship to child: _____

Please describe any custody arrangements and who lives in that household:

_____

_____

_____

Are there any other siblings who do not live in either household? _____

Any family changes/stressors (relocation, separation, etc.): _____

_____

Patient Name:
Patient DOB:

Current Parents or Guardians:

Name	Occupation	Medical, Social, Emotional or School Problems
Mother:		
Father:		
Other:		
Other:		

PREGNANCY HISTORY

Is the pregnancy history of the biological mother available? No _____Yes _____(If "no" skip to next section**)
How many times has the biological mother been pregnant? ____
How many children does the biological mother have now? ____
Did the biological mother lose any pregnancies? How many? ____
Biological birth order of this child. (*1st child, 2nd, 3rd, etc.*) ____

Instructions: Answer these questions about the pregnancy ***with the child being evaluated***
Did the mother receive assisted reproductive technology? (in vitro fertilization, frozen eggs : No_____ Yes_____ Unsure_____
Biological mother's age at birth of child: _____ Years
Biological father's age at birth of child: _____ Years
Check if the mother had any of the following illnesses /events during the pregnancy **with this child?**

- ☐ Fever over 101ºF: (excluding those occurring during labor & delivery)
- ☐ Any infection (describe): _____
- ☐ Any other complications? (Excess vomiting, high blood pressure, premature labor, etc.)- Describe:

_____

_____

MEDICATIONS/ DRUGS DURING PREGNANCY:

Check the one that best describes alcohol use during pregnancy:
____Unsure/ _____No alcohol use/ _____1 drink or less per week/ ____1 drink per day/ ____2 or more drinks per day

Check the one that best describes tobacco use during pregnancy:
____ Unsure/ _____None/ _____Less than 10 cigarettes a day/ ____1 pack or more per day

Was there any other drug use during the pregnancy? Describe: _____

Patient Name:
Patient DOB:

LABOR AND DELIVERY

Hospital of Birth: _____ Location: _____

Birth Weight: _____

What was the length of the pregnancy? In **Weeks**: _____ OR **Months**:_____

Was this child born by: _____**Vaginal delivery**/ _____**Cesarean section** (Why was a C-section done?: _____

Was this child: _____Singleton/ _____One of twins/ _____One of triplets/ _____Other Multiple

If "Twins", what type: ____Identical/ _____Fraternal _____ Unsure

Were there any labor or delivery complications? (Breech, fetal heart rate drops, cord around neck, etc.)- Describe:

_____

_____

NEWBORN PERIOD:

Did this child turn blue or stop breathing? _____
Did this child have Jaundice that needed Phototherapy? _____
Did this child have an infection? _____
Was the baby admitted to the NICU (neonatal intensive care unit)?
If "Yes", for what reason? _____

_____

How old was your child when discharged from the NICU: _____

THE CHILD's MEDICAL HISTORY

Hospitalizations:

After birth, has this child ever been admitted to the hospital either directly or via the emergency room?
If yes, complete the following:

Dates	Hospital	How long	Reason

Patient Name:
Patient DOB:

Surgeries:

Including those during the newborn period, has this child ever had an operation?
If yes, please complete the following:

Age	Hospital/Clinic	Surgery	Reason for surgery

Injuries:

Has this child had any serious injuries or concussions? If yes, please explain:

_____

_____

Allergies

Is this child allergic (or thought to be allergic) to any foods, medications, or other substances, dusts, or pollens? If yes, please complete the following

Allergy or suspected allergy	What happens when this occurs

Patient Name:
Patient DOB:

Current Medications:

Date First Prescribed	Medication Name	Dose	Prescribed for	Response	MD/NP

Please list any *past* medications for psychological/behavioral problems:

Dates prescribed	Medication Name	Dose	Prescribed for	Response	MD/NP

Hearing:

Hearing problems? (explain):

Date of most recent hearing evaluation and results, if known:

Vision:

Vision problems? (explain):

Date of most recent vision evaluation and results if known:

Immunizations:

Are this child's immunizations up to date? : _____ If no, please explain._____

Exposures:

Has this child had blood drawn to test lead level? _____ Test for Anemia? _____

Was the lead level elevated? _____ Was any treatment of the child required? _____

Has this child ever ingested any toxins or poisons? Describe: _____

Has this child been exposed to physical/emotional/sexual abuse? Please explain:

_____

_____

To the best of your knowledge, has this child:

Consumed alcohol_____

Taken illegal drugs_____

Violated the law_____

Destroyed property_____

Patient Name:
Patient DOB:

Other Health or Mental Health problems:

Are any of these health concerns a problem for the child currently, or were they a concern in the past?
Check if YES and Please Explain:

- ☐ Headaches:
- ☐ Ear, nose and throat problems:
- ☐ Dental problems:
- ☐ Heart conditions:
- ☐ Asthma or other lung problem:
- ☐ Recurrent Nausea/ Vomiting:
- ☐ Reflux:
- ☐ Diarrhea:
- ☐ Constipation:
- ☐ Stomach/abdominal pain:
- ☐ Feeding problem:
- ☐ Kidney/ bladder/genital problems
- ☐ Bone or joint problems:
- ☐ Blood or anemia problems:
- ☐ Skin conditions:
- ☐ Endocrine or hormone problems:
- ☐ Seizures:
- ☐ Tics or repetitive, non-purposeful movements:
- ☐ Genetic Disorder:
- ☐ Loss of skills/ regression:
- ☐ Depression:
- ☐ Bipolar mood disorder:
- ☐ Anxiety disorder:
- ☐ Obsessive compulsive disorder (OCD):
- ☐ Attention Deficit Hyperactivity Disorder (ADHD):
- ☐ Autism Spectrum, Asperger, pervasive Developmental Disorder:
- ☐ Other Health Condition- Describe: _____

_____

Was this child born with any birth defects and/or medical/health conditions not noted above?:

_____

_____

Patient Name:
Patient DOB:

Physical Disability:

Does this child have a physical disability such as cerebral palsy or spina bifida that makes it difficult for him or her to walk or get from place to place?_____
Describe:_____

If YES: Does this child wear braces or AFOs? _____
Does this child use a walker or wheelchair? _____
Does this child require other medical devices such as oxygen, tracheostomy, or feeding tube? _____

Describe:_____

Daily Living Skills:

Does this child settle down to sleep? _____

Sleep through the night without disruption? _____

Experience nightmares, night terrors, sleep walking, sleep talking? _____

Is this child a very restless sleeper? _____

Does this child snore? _____

Have there been any recent changes in sleep patterns within the past six months?_____

_____

How many hours per day does this child spend:

watching tv _____ playing video games _____ on the internet _____

Eating_____

Appetite _____

Variety of foods_____

Behavior at meals_____

Any recent changes in appetite in the past 6months?_____

_____

Toileting_____

Independent?_____

Needs Help/ Reminders?_____

Regular Accidents?_____

Patient Name:
Patient DOB:
DEVELOPMENTAL MILESTONES:

Developmental History: Please tell us if your child has learned any of the following skills, even if he or she has stopped doing that skill. If "yes" please provide your best estimate of the age first learned.

	A- Achieved? Yes No	B- If Yes age first achieved	C- Continues to have this skill? Yes No
Walk (without holding on):			
First Words (other than mama/ dada)			
First Phrases (2-3 words)			
Toilet trained			
Were there concerns about development?			

If there were concerns please list them.

_____

_____

COORDINATION

Rate this child on the following skills:	Good	Average	Poor		Good	Average	Poor
Walking				Shoelace tying			
Running				Buttoning			
Throwing				Writing			
Catching				Athletic abilities			
Excessive number of accidents compared to other children							

COMPREHENSION AND UNDERSTANDING

Do you consider this child to understand directions and situations as well as other children his or her age? If not, why not?

_____

_____

How would you rate this child's overall level of intelligence compared to other children?

Below Average _____ Above Average_____ Average_____

Patient Name:
Patient DOB:

PEER RELATIONSHIPS

Does this child seek friendships with peers? _____

Is this child sought by peers for friendship? _____

Does this child play with children primarily his or her own age? _____

Younger? _____ Older? _____

Has this child's behavior caused him/her to be neglected or rejected by peers? _____

Describe briefly any problems this child may have with peers _____

_____

_____

_____

HOME BEHAVIOR

How well does this child work for a short term reward? _____

How well does this child work for a long term reward? _____

Does this child create more problems, either purposeful or non-purposeful, within the home setting than his or her siblings?

_____

Does this child have difficulty benefiting from his experiences? _____

Types of discipline you use with this child _____

_____

_____

Do both parents agree on disciplinary practices? _____

Is there a particular form of discipline that has proven effective? _____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? If so, please describe. _____

_____

Have family/child participated in counseling/therapy? If so, please describe. _____

Has the child received a psychological evaluation before? If yes, please provide approximate dates and provider information.

_____

Patient Name:
Patient DOB:

Family History – The questions below ask about the family history of the child. Please let us know if there is someone in the child's family who has each disorder listed by checking the box "yes", "no", or "unsure". If "yes" which family member. Include all biological (blood) relatives.

Disorder	No	Yes	Unsure	If "yes" specify relationship to the child	
Autism Spectrum Disorder				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other _____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Learning Disability				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other _____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Intellectual Disability				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Speech Delay or disorder (received speech therapy)				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Genetic Disorder (describe)				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
ADHD				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Anxiety, Depression, Obsessive Compulsive Disorder				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____

Patient Name:
Patient DOB:

Disorder	No	Yes	Unsure	If "yes" specify relationship to the child	
Schizophrenia				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Tics or Tourette's Syndrome				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Seizures				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Fragile X				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Tuberous Sclerosis or Neurofibromatosis				○ Mother ○ Sister	○ Father ○ Brother
				Mothers side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Auto- Immune Disorders				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Gastrointestinal Diseases				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____
Heart disease (sudden death, Rhythm disorder)				○ Mother ○ Sister	○ Father ○ Brother
				Mothers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____	Fathers Side ○ Grandmother ○ Uncle ○ Grandfather ○ Cousin ○ Aunt ○ Other_____

Patient Name:
Patient DOB:

ADDITIONAL COMMENTS: please make any additional remarks you would like to make regarding this child.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you,

Please return to Elliot Developmental Pediatrics so that we can set your child up for an appointment with our office.

Elliot Developmental Pediatrics
275 Mammoth Rd Suite 1
Manchester NH 03103
603-663-3222