Rady Children's Hospital-San Diego
Developmental Services
3020 Children's Way
San Diego, CA. 92123-4282

DTR1394

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Developmental Questionnaire

IDENTIFICATION

Child's Name: _____ Birthdate: _____ Sex: ❒Male ❒Female Age: _____

Child's Primary Care Physician: _____

Person Completing this Form: _____ Date: _____

Relationship to Child: _____

STATEMENT OF THE PROBLEM

Describe as completely as possible the reason for referral / concern: _____

When was the problem first noticed? _____

Has your child received help for this problem? If so, what type? _____

Where? _____ When? _____

What are your expectations for today's visit? _____

GENERAL DEVELOPMENT

A. FAMILY HISTORY

Please list siblings:

NAME	SEX	DATE OF BIRTH

Have any relatives (including parents, grandparents, siblings, aunts, uncles, cousins) had any of the following?

	YES	NO	IF YES, WHO?
Autism			
Developmental problem			
Drug or alcohol problems			
Hearing problems			
Hyperactivity			
Learning problems			
Mental retardation			
Psychological problems			
Seizures or epilepsy			
Severe behavior problems			
Speech problems			

Highest grade level attained by: Parent 1 _____ Parent 2 _____

Parent 1 occupation: _____ Parent 2 occupation: _____

What other languages are spoken in the home? _____

By whom are they spoken and how often? _____

Have there been any recent significant stress-producing events? ❒Yes ❒No For whom? ❒Parent ❒Child If yes, explain: _____

_____

Do you or your child have any anxieties or fears related to your visit today? ❒Yes ❒No If yes, explain: _____

_____

B. PREGNANCY AND BIRTH HISTORY

Were there any complications, illnesses, accidents, or stress-producing events during pregnancy? ❒ Yes ❒ No

If yes, please explain: _____

Did the mother use prescription, non-prescription or street drugs, herbs, or alcohol during pregnancy? ❒ Yes ❒ No

If yes, please explain: _____

Was the baby born prematurely? ❒ Yes ❒ No How many weeks early? _____

Where was the baby born? _____ How long was the infant in the hospital? (days/months)_____

Were there any unusual problems at birth? ❒ Breathing difficulty ❒ Feeding difficulties

Explain: _____

_____

Were there any bruises or abnormalities of the child's head/body? _____

What did the baby weigh at birth? _____

What were the child's APGAR scores? _____

C. MEDICAL HISTORY

Is the child now under the care of a doctor(s)? ❒Yes ❒ No Who?:_____ Why?: _____

Are immunizations up-to-date? ❒Yes ❒ No

Is the child in pain? ❒Yes ❒ No If yes, please explain: _____

Is the child taking medication? ❒Yes ❒ No Type(s)? _____ Why?: _____

Is the child taking herbs? ❒Yes ❒ No Type(s)? _____ Why?: _____

Do you think hearing is normal? ❒Yes ❒ No Has child's hearing ever been tested? ❒Yes ❒ No If so, when?: _____

Where?: _____ Results?: _____

Do you think your child's vision is normal? ❒Yes ❒ No Does your child wear glasses? ❒Yes ❒ No

At what age did the following occur? Please explain.

	AGE	EXPLAIN		AGE	EXPLAIN
Adenoidectomy			Eye Problems		
Allergies			Heart Problems		
Asthma			High Fevers		
Blood Disease			Meningitis		
Chronic Colds			Muscle Disorder		
Dental Problems			Nerve Disorder		
Diabetes			Seizures		
Ear Infections			Tonsillectomy		
Encephalitis			Other		

Describe any other serious illnesses, injuries, physical problems, hospitalizations not mentioned above.

_____

_____

_____

_____

_____

D. DEVELOPMENTAL HISTORY

At what age did the following occur?

Held head up:	Rolled over:	Sat alone unsupported:	Crawled:	Walked Alone:
Weaned from bottle:	Said first words:	Put words together:	Was toilet trained:	Followed simple directions:

How much of the child's speech do you understand? ❒ 0% ❒ 10% ❒ 25% ❒ 50% ❒ 75% ❒ 100% ❒ Too young to talk

Check these as they applied / apply to the child:

	YES	NO	EXPLAIN (give age)
Generally indifferent to sound			
Does not respond when spoken to			
Responds to noises, not speech			
Irregular sleep pattern			
Difficulty sucking			
Difficulty chewing			
Difficulty swallowing			
Prefers soft foods			
Excessive drooling			
Food comes out nose			

Has the child ever been diagnosed with:

√		BY WHOM	WHEN	DO YOU AGREE? Yes	No
	Autism Spectrum Disorder				
	Cerebral Palsy				
	Developmental Syndrome				
	Fine Motor Problem				
	Gross Motor Problem				
	Head Injury				
	Hearing Loss				
	Learning Problem				
	Mental Retardation				
	Neurological Problem				
	Speech and/or Language Problem				
	Visual Impairment				
	Other (specify)				

Mark any evaluations or therapy received. If received by the child, mark a "C"; if received by another family member, mark an "F".

_____ Speech-Language _____ Occupational Therapy _____ Behavioral _____ Psychological

_____ Physical Therapy _____ Hearing _____ Counseling _____ Nutritional

_____ Parent Training _____ Educational _____ Developmental

Describe results: _____

_____

_____

_____

E. SOCIAL BEHAVIOR

Check these if they apply to the child:

- ❒ Floppy when held
- ❒ Tense when being held
- ❒ Resists being held
- ❒ Cries a lot, irritable, fussy
- ❒ Underactive
- ❒ Overactive
- ❒ Aggressiveness
- ❒ Biting
- ❒ Injures self
- ❒ Lives in a world of his/her own
- ❒ Rocking
- ❒ Prefers to play alone
- ❒ Separation difficulties
- ❒ Difficulty getting along with children
- ❒ Difficulty getting along with adults
- ❒ Difficulty staying with an activity
- ❒ Toilet training problems
- ❒ Difficult to discipline

How do you discipline the child? _____

_____

Describe any behavior that is a problem to the parents: _____

_____

_____

_____

F. EDUCATIONAL HISTORY

Did / Does child attend day care or preschool? ❒ Yes ❒ No Where? _____

School now attending: _____ Grade: _____

❒ Regular Education ❒ Special Education ❒ Therapy Services ❒ In-home Program

Performance: _____

_____

_____

Does the child remember homework instructions? _____

Does the child follow directions in school? _____

Does the child retain information taught? _____

What is your impression of the child's learning abilities? _____

Does your child have a current IEP or IFSP? ❒ Yes ❒No Where? _____

What would you like to accomplish for your child through this assessment process? _____

_____

_____

_____