Rady Children's Hospital San Diego

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

*DTF14

PATIENT INFORMATION

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

# Developmental Questionnaire – DEC/ADI/KidSTART

Name of person completing this form: _____ Date: _____

Relationship to child: _____

**CHILD IDENTIFICATION**

Child's Name: _____ Birthdate: _____ Current Age: _____

Child's Sex: ☐ Male ☐ Female

**Select Child's Primary Ethnicity**
Not Hispanic ☐ (please select one from Primary Race below)
Hispanic (select one): Cuban ☐ Dominican ☐ Mexican/American ☐ Puerto Rican ☐ Salvadorian ☐ Other ☐_____

**Select Child's Primary Race** (select one)
Asian Indian ☐ Black/African American ☐ Cambodian ☐ Chaldean ☐ Chinese ☐ Eskimo/Alaskan Native ☐
Ethiopian ☐ Filipino ☐ Guamanian ☐ Hawaiian Native ☐ Hmong ☐ Iranian ☐ Iraqi ☐ Japanese ☐
Korean ☐ Laotian ☐ Mien ☐ Other Asian ☐ Other Non-White/Non-Caucasian ☐ Other Pacific Islander ☐
Samoan ☐ Sudanese ☐ Vietnamese ☐ White/Caucasian ☐ Unknown/Not Reported ☐

What is the primary language spoken in the home? _____ What language is spoken in daycare (if applicable) _____

What other language(s) does the child speak? _____ What other language(s) does the child understand _____

What other languages are spoken in the home? _____ By whom are they spoken and how often? _____

**STATEMENT OF THE PROBLEM**

Who referred your child for this evaluation? _____

Describe the reason for referral / concern: _____

_____

When was the problem first noticed? _____

**PREGNANCY AND BIRTH HISTORY**
At what point in the pregnancy did the mother first know she was pregnant? _____

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: _____

Did the mother use tobacco during pregnancy? ☐ Yes ☐ No Did the mother receive prenatal care during pregnancy? ☐ Yes ☐ No

Was the baby born prematurely? ☐ Yes ☐ No If yes, how many weeks early? (from Gestational Age) _____

How was the baby delivered? ☐ Vaginal birth ☐ Planned cesarean (Reason: _____) ☐ Emergency cesarean (Reason: _____)

Where was the baby born? _____

Were there any complications with labor and delivery? ☐ Yes ☐ No If yes, please explain: _____

_____

What did the baby weigh at birth? _____ What were the child's APGAR scores? _____

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

Were there any problems at or after birth? ☐ Breathing difficulties ☐ Nursing/Feeding difficulties ☐ Other: _____

Please explain: _____

How long was the infant in the hospital after birth? _____

**MEDICAL HISTORY**

Child's Primary Care Physician: _____

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? _____

Has the child taken psychiatric medications in the past? ☐ Yes ☐ No

If yes, please list any medications related to child's presenting concerns: _____

Is the child taking herbs / Alternative treatments? ☐ Yes ☐ No Type(s)? _____ Why? _____

Is the child on any special diets? ☐ Yes ☐ No Type(s)? _____

Do you think your child's 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 Has child's vision ever been tested? ☐ Yes ☐ No

If so, when? _____ Where? _____ Results? _____

Does your child wear glasses? ☐ Yes ☐ No

Does your child have any allergies? ☐ Yes ☐ No If yes, please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please explain: _____

When was your child's last visit with the PCP? Date of visit: _____

When was your child's last visit with the dentist? Date of visit: _____

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

_____

**At what age did the following occur?**

| | | | Age | | | | Age | | | | Age |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Allergies | Yes | No | | G-Tube | Yes | No | | Meningitis | Yes | No | |
| Asthma | Yes | No | | Genetic Disorder | Yes | No | | Nerve/muscle disease | Yes | No | |
| Craniosynostosis Repair | Yes | No | | Hearing Problems | Yes | No | | Recurrent URI | Yes | No | |
| Diabetes mellitus | Yes | No | | Hydrocephalus | Yes | No | | Seizures | Yes | No | |
| Ear Infections | Yes | No | | Jaundice | Yes | No | | Vision Problems | Yes | No | |

**SURGICAL HISTORY**

| | | | Age | | | | Age | | | | Age |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Adenoidectomy | Yes | No | | Tonsillectomy | Yes | No | | Eye Surgery | Yes | No | |
| Ear tubes | Yes | No | | Congenital/birth anomaly | Yes | No | | Other | Yes | No | |

**DEVELOPMENTAL HISTORY**
**At what age did the following occur?**

| | | | |
|---|---|---|---|
| Held head up: | Rolled over: | Smiled socially: | Sat alone unsupported? |
| Crawled: | Cruised: | Walked alone: | Ran: |
| Babbled: | Said first words: | Put words together | Used sentences: |
| Weaned from the bottle: | Fed self with a spoon: | Toilet trained during the day:<br>Toilet trained during the night: | Followed simple directions: |

Describe the child as an infant/toddler (fussy, easy-going, social, serious):

_____

Has the child experienced any loss of skills (e.g., was talking and stopped)?

| | | |
|---|---|---|
| No | Yes | If yes, please describe and list age: |

How much of the child's speech do you understand? ☐ 0% ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ N/A (not talking)

| **Indicate if your child has/had the following difficulties and note the age when concerns presented** | | **Describe difficulties/concerns:** |
|---|---|---|
| Sleep difficulties | ☐ Current ☐ Past (Age: _____) | |
| Feeding difficulties | ☐ Current ☐ Past (Age: _____) | |
| Food aversions | ☐ Current ☐ Past (Age: _____) | |
| Toileting issues | ☐ Current ☐ Past (Age: _____) | |
| Constipation issues | ☐ Current ☐ Past (Age: _____) | |
| Chronic diarrhea | ☐ Current ☐ Past (Age: _____) | |
| Sensory issues | ☐ Current ☐ Past (Age: _____) | |
| Safety concerns | ☐ Current ☐ Past (Age: _____) | |
| Behavioral concerns | ☐ Current ☐ Past (Age: _____) | |
| Motor Delays | ☐ Current ☐ Past (Age: _____) | |
| Coordination Difficulties | ☐ Current ☐ Past (Age: _____) | |

Describe any other concerns you had/have about your child's development or behavior.

_____

_____

_____

**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:

_____

_____

**FAMILY HISTORY**
**Please list all the people who live in the home with your child:**

| NAME | RELATIONSHIP TO CHILD | SEX | DATE OF BIRTH |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have there been any recent changes to the family/ family structure? (moves, divorce, etc.) ☐ Yes ☐ No
If yes, please explain: _____

_____

_____

Marital Status: Married _____ Never Married _____ Separated _____ Divorced _____
Is there a custody agreement? Please explain: _____

Parent/Caregiver 1: _____
Name: _____
Relationship to child: _____
What does child call parent/caregiver 1: _____
Age at birth of child: _____
What is the highest level of education?

☐ Less than High School
☐ High School/GED
☐ Associates Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctoral Degree
☐ Other: _____

Occupation: _____

Parent/Caregiver 2: _____
Name: _____
Relationship to child: _____
What does child call parent/caregiver 2: _____
Age at birth of child: _____

☐ Less than High School
☐ High School/GED
☐ Associates Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctoral Degree
☐ Other: _____

Occupation: _____

If one or both of the biological parents are different from the parent/caregiver noted above, do you have any additional information regarding the biological parent(s) that might assist us in evaluating the child? ☐ Yes ☐ No

_____

_____

_____

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

_____

_____

_____

Has the child been exposed to trauma or traumatic events, either currently or in the past (medical, physical or sexual abuse, neglect)? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Do you have any immediate safety concerns for the child? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

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

| | Yes | No | If yes, who/explain |
|---|---|---|---|
| ADHD Hyperactivity/Inattention | | | |
| Anxiety | | | |
| Autism Spectrum Disorder | | | |
| Behavior Problems | | | |
| Depression/mood difficulties | | | |
| Developmental delays | | | |
| Drug or Alcohol Abuse | | | |
| Hearing problems | | | |
| Intellectual Disability (previously called Mental Retardation) | | | |
| Learning difficulties | | | |
| Unknown Mental Illness | | | |
| Obsessions/Compulsions | | | |
| Psychosis | | | |
| Seizures or epilepsy | | | |
| Speech delays/problems | | | |
| Suicide Attempts/Completions | | | |

Please list any other conditions experienced by family members here: _____

_____

**EDUCATIONAL HISTORY**

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

How many schools has your child attended since 1st grade? _____

Name of school now attending: _____ Current Grade: _____

Current academic standing:

☐ Public School
☐ Private School
☐ Charter School
☐ Home Schooled
☐ Other: _____

☐ Regular Education Classroom
☐ Special Education Classroom
☐ Self-Contained Classroom
☐ Resource Classroom
☐ Other: _____

Does the child receive any of the following at school:

☐ Academic Tutoring
☐ 1:1 aide
☐ Speech/language Therapy
☐ Occupational Therapy
☐ Physical Therapy
☐ Adaptive Physical Education (APE)
☐ Extended School Year (ESY)
Other: _____

**Current academic placement/supports:**

Does the child have an IEP? ☐ Yes ☐ No If yes, what is the child's educational classification on the IEP? _____

Does the child have a 504 plan? ☐ Yes ☐ No

Has your child repeated a grade? ☐ Yes ☐ No If yes, which grade? _____

Has your child experienced prolonged school absences? ☐ Yes ☐ No

Do you have concerns about your child's academic performance: ☐ Yes ☐ No

If yes, please describe concerns: _____

_____

_____

Do you have concerns about your child's behavior at school: ☐ Yes ☐ No

If yes, please describe concerns: _____

_____

_____

**EVALUATION/THERAPEUTIC HISTORY**

**Has your child ever had the following screenings/evaluations? Please indicate all screenings/evaluations child has received.**

| | ✓ | BY WHOM | WHEN / WHERE | RESULTS / DIAGNOSIS |
|---|---|---|---|---|
| Developmental Screening (e.g., First 5, DSEP) | | | | |
| Developmental or Psychological Evaluation | | | | |
| Speech and Language Evaluation | | | | |
| Occupational Therapy Evaluation | | | | |
| Physical Therapy Evaluation | | | | |
| Evaluation through the School District | | | | |
| Evaluation through CA Early Start/ San Diego or Inland Regional Center | | | | |
| Other (specify): | | | | |

Additional information: _____

_____

_____

**Has your child ever been diagnosed with any of the following?**

| ✓ | | BY WHOM | WHEN | DO YOU AGREE? | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| | Attention Deficit Hyperactivity Disorder | | | | |
| | Autism Spectrum Disorder | | | | |
| | Cerebral Palsy | | | | |
| | Developmental Delay | | | | |
| | Fine Motor Delays | | | | |
| | Gross Motor Delays | | | | |
| | Head Injury | | | | |
| | Hearing Loss | | | | |
| | Learning Disorder | | | | |
| | Intellectual Disability | | | | |
| | Neurological Disorder | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | Speech and/or Language Disorder | | | | |
| | ADHD | | | | |
| | Depression/Mood Disorder | | | | |
| | Anxiety | | | | |
| | Visual Impairment | | | | |
| | Other (specify) | | | | |

Additional information: _____

_____

_____

**INTERVENTION SERVICES**

**Has your child ever received the following services?**

| | | | DATE SERVICE BEGAN | SERVICE LOCATION |
|---|---|---|---|---|
| CA Early Start | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| San Diego or Inland Regional Center | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Speech and Language Therapy | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Occupational Therapy | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Physical Therapy | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Behavioral Therapy (ABA) | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Cognitive Behavioral Therapy (CBT) and/or Play Therapy | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Counseling/Mental Health | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Social Skills intervention | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Parent Training | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Nutrition/Feeding Interventions | ☐ Yes ☐ No | ☐ Current ☐ Past | | |
| Tutoring/Educational Therapy | ☐ Yes ☐ No | ☐ Current ☐ Past | | |

Additional information: _____

_____

_____

_____

**GOALS**

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

_____

_____

_____

_____

_____