UC San Diego SCHOOL OF MEDICINE

THE DEVELOPMENTAL-BEHAVIORAL PEDIATRICS CLINIC **Clinic Address: 7910 Frost Street, Suite 280, San Diego, California 92123**

Sheila Gahagan, MD, MPH Division Chief | **Yi Hui Liu, MD, MPH** Medical Director | **Adam Braddock, MD,M.Phil ▪ Lauren Gist, MD, MPH Theodora Nelson, MD ▪ Carolyn Sawyer,**

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Dear Parent/Caregiver:

The enclosed brochure explains how to prepare for your appointment at the UCSD Developmental-Behavioral Pediatrics Clinic. Please read the entire brochure **FIRST**, as it may answer your questions or concerns. The following steps outline the process to obtain an appointment:

❶ **Primary Care Physician (PCP) or referring provider faxes a referral to 858-496-9257.**
The form is included in this packet for you to give to your PCP to complete, however check with your PCP to see if they have already started the referral process. The referral form from your PCP must include the patient's diagnosis code(s).

❷ **Insurance Authorization** –For an appointment to be scheduled for your consultation, we must have authorization by your insurance or your agreement to self-pay. You will be responsible for any co-pay, deductible or self-payment at the time of your visit.

❸**Child Registration Form** and **Questionnaires**
Ask your child's teacher (or teachers, if they have multiple teachers) to complete the **School Questionnaire**. If your child is not in school, a babysitter, daycare provider, camp counselor, tutor, etc. may fill out the school questionnaire instead. **Parents must complete the New patient forms and Parent Questionnaire within two weeks of scheduling your appointment.**

All questionnaires must be complete and received by the Developmental Behavioral Pediatrics office within 2 weeks of scheduling your appointment to avoid cancellation or rescheduling.

❹ **COMPLETED forms** may be sent to Developmental-Behavioral Pediatrics in one of 3 ways:

Via U.S. Mail - UCSD Pediatric Associates
Attn: Developmental-Behavioral Pediatrics
7910 Frost St, Suite 280
San Diego, CA 92123

Via Fax - (**858) 496-9257**

Drop Off at The Clinic - **UCSD Developmental Behavioral Pediatrics**
7910 Frost Street, Suite 280,
San Diego, CA 92123

❺ You may provide **additional documentation** that you feel would be helpful for your child's evaluation, such as:

- School documents, such as IEPs and School Assessments
- Evaluations done at other medical facilities (e.g., neurology, genetics, etc.)
- Evaluations done at nonmedical facilities such as California Early Start, Regional Center, First 5
- Lab tests or imaging studies done outside of Rady Children's Hospital
- Therapist/Counselor Notes or a letter from the therapist/counselor, if your child has seen one.

❻ **Scheduling -** After all steps are completed, staff will contact you to schedule your visit.

Please call (858) 496-4860 if you have any questions

We look forward to serving your family!

Developmental-Behavioral Pediatrics Clinic

7910 Frost Street Suite 280 San Diego, CA 92123
Sheila Gahagan, MD, MPH ▪ Yi Hui Liu, MD, MPH ▪ Martin Stein, MD
Adam Braddock, MD, MPhil ▪ Lauren Gist, MD, MPH
Theodora Nelson, MD ▪ Carolyn, Sawyer, MD

Consultation Request Form **Fax completed form and supplemental information to 858-496-9257**

Patient Information:

Child's Name: _____Date of Birth: / / Age: ____ Gender: ☐ M ☐F
Caregiver's Name: _____

Relation: ☐ Parent ☐ Foster Parent ☐ Other: _____

Will an interpreter be needed? ☐ No ☐Yes Which Language? _____
Mailing Address: _____
City _____ State _____ ZIP _____
Home ( ) _____Alt ( ) _____ Email: _____
In order to schedule an appointment, an insurance authorization must be in place. Please check if family plans to self-pay _____ Authorization required ___YES ____NO

Insurance Carrier/Type: _____
Subscriber Name: _____Subscriber ID: _____

*Please have your staff request an authorization for **ALL** of the following CPT codes, a level 5 consultation visit (99245), developmental screening (96110), developmental testing (96112, 96113x3), several follow-up visits (99215, 99214, 99213), and prolonged service with direct patient contact (99354).*

Referring Provider/Primary Care Physician:
Referring Provider Name _____Clinic Name _____
Phone number _____Fax number for reports _____

REQUIRED: Please describe in detail the primary reason for this consultation_____
_____
_____

****For concerns of abnormal development or learning problems, please ensure that referrals for appropriate concurrent services have also been submitted (e.g., school IEP request, speech therapy, etc.).****

Consultation concerns: ☐diagnosis ☐2nd opinion ☐medical workup ☐medication management ☐recommendations for services/resources

Diagnosis: ☐Expressive language delay—F80.1; ☐Receptive language delay or expressive and receptive language delay—F80.2 ☐Gross motor delay—F82 ☐Fine motor delay —F82 ☐Social delay —F88 ☐ADHD-inattentive—F90.0 ☐ADHD-hyperactive/impulsive or combined type—F90.1 F90.2 ☐Autism Spectrum Disorder— F84.0 ☐Anxiety—F41.9 ☐Depression—F32.9 ☐Learning difficulties—F81.9 ☐Academic underachievement —Z55.3 ☐Oppositional behaviors/ODD—F91.3 ☐Intellectual disability —F79 ☐Feeding problems —R63.3 ☐Sleep problems —G47.9

Is the patient currently under the care of a psychiatrist: ☐Yes (If yes, please provide contact information and records?)
☐ No

Other concerns with documented dx code_____
_____
_____

REQUIRED: Dx codes must be documented in EPIC referrals and on hard copy request.

***Note:** We are unable to evaluate children with complex or emergency mental health needs, or those taking multiple psychotropic medications. We do not provide comprehensive psychological testing, ongoing behavioral therapy or ongoing mental health counseling.*

_____ _____
Primary Care Physician's or Referring Provider's signature and specialty ***Date:***

(05/19/2020)

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Developmental-Behavioral Pediatrics
Child Registration Form

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PLEASE PRINT

Child's Name:	**Sex: M F**	**Date of Birth:**
Child's Mailing Address:	City:	State/ZIP:
Home Phone, with area code: ( )	Child's Insurance:	
Child's Social Security Number:	Child's Race/Ethnicity:	

Child's Legal Guardian (please circle): Mother Father Both Other (specify):

Mother's Name:	**Date of Birth:**	**Home Phone: ( )**
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

Father's Name:	Date of Birth:	Home Phone: ( )
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

If there is another guardian other than the parents of this child, please complete guardian information below:

Guardian's Name:	Date of Birth:	Home Phone: ( )
Relationship to child:	Marital Status: S M W D Sep	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

PARENTS: Before we can evaluate your child, we need to collect information from your child's medical records, school, and other professionals involved in your child's care. We need your permission to do this. Please sign below.

MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Signature_____ Date_____

UCSD Developmental Behavioral Pediatrics

Dear Parents;

Effective October 1, 2015 there will be a fee for appointments not cancelled 48 hours in advance and missed appointments.

New patients will be charged $50.00 and returning patients will be charged $25.00.

_____

Parent/Guardian Signature

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Developmental-Behavioral Pediatrics
Parent Questionnaire

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Child's Name (Last, First) :	Date of Birth:	Age:	Sex : M F	Today's Date:
Address: City: State: Zip:				Phone:
Child's Race (circle) : Hispanic or Latino White American Indian/ Alaskan Native Don't Know Black or African American Asian or Pacific Islander Other, specify: _____				
Child's Doctor:	Doctor's Office Name:			Doctor's Phone:
Name of person completing this form:	Relationship to child:			Phone:

CHIEF CONCERN:

1. **Who** suggested that your child be seen in the clinic for developmental or behavior problems?

2. What **concerns** do you have about your child?

a.

b.

c.

3. **How long** have you been concerned about your child's development or behavior?	**4**. Please check ONE: Overall, the above concerns are ☐ **mild**, ☐ **moderate**, or ☐ **severe**?	**5**. Please check ONE: My concerns are ☐ **improving**, ☐ **staying the same**, or ☐ **getting worse**?

6. Please describe your child's **strongest areas at home**:

a.

b.

c.

7. Goals for Visit: What do you hope to accomplish? (check all that apply):

☐ Better understanding of my child ☐ Guidance for development
☐ To determine a diagnosis ☐ Guidance for behaviors
☐ Medication to help ☐ Guidance for resources

HISTORY: Birth

1. How much did your child weigh at birth? _____ pounds _____ounces

2. Biological Father's age at birth of your child:

3. Biological Mother's age at birth of your child:

4. Number of living children: _____

5. Number of pregnancies prior to your child:

6. Number of miscarriages prior to your child:

Y	N	
		7. Were there any **problems during the pregnancy**? Specify:
		8. Were there any **problems during labor / delivery** or **following the birth**? Specify:
		9. Was your child born by **Cesarean / C-Section**? If yes, circle: **planned** **emergency** If yes, specify why:
		10. Was your child born **two or more weeks before** the "due date"? If yes, how many weeks early was your child?
		11. Were any substances or **medications used by the mother** during the pregnancy? ____Beer / Wine ____Alcohol ____Cocaine ____Prescription medication: ____Tobacco ____Marijuana ____Methamphetamine (Crystal / Ice) ____Other:

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Developmental-Behavioral Pediatrics
Parent Questionnaire

Child's Name (Last, First):

HISTORY: Development

Fill in the Age at which your child could:

Sit _____ Say "mama/dada" _____ Use the toilet (able to stay dry during day) _____

Walk _____ Say first word (other than "mama/dada")_____ Read simple words _____

Say two words together (such as "more milk")_____ Speech could be understood by strangers _____

Check the skills which your child can do for himself or herself:

☐ Undress ☐ Use utensils ☐ Ride a tricycle ☐ Write name

☐ Dress ☐ Drink out of a regular open cup ☐ Ride a bicycle ☐ Write legibly

HISTORY: Health

Y	**N**	1. Has your child had any **major or chronic health problems**? Specify:
Y	**N**	2. Has your child ever been **hospitalized?** Specify:
Y	**N**	3. Has your child ever had **surgery**? Specify:
Y	**N**	4. Does your child have any **allergies?** (e.g. medications, foods, environmental) Specify:
Y	**N**	5. Has your child had any **vision/eye** problems? Specify:
Y	**N**	6. Has your child had any **hearing/ear** problems? Specify:
Y	**N**	7. Has your child had frequent **ear infections**?
Y	**N**	8. Does your child have **frequent headaches**? Specify:
Y	**N**	9. Has your child lost **consciousness** or had a **serious head injury**? Specify:
Y	**N**	10. Does your child have problems with **runny nose, congestion, itchy eyes**? Specify:
Y	**N**	11. Does your child have **dental** problems? Specify:
Y	**N**	12. Does your child have any problems with **drooling, swallowing, or choking**? Specify:
Y	**N**	13. Does your child have problems with **breathing, coughing, or catching his/her breath**? Specify
Y	**N**	14. Does your child have any problems with their **heart, rapid heartbeat, chest pain, or fainting**? Specify:
Y	**N**	15. Does your child have **frequent stomachaches**? Specify
Y	**N**	16. Does your child have problems with **heartburn, reflux, nausea, or vomiting**? Specify
Y	**N**	17. Does your child have problems with his/her **bowel movements, diarrhea, or constipation**? Specify
Y	**N**	18. Does your child have **stool / bowel accidents**? Specify:
Y	**N**	19. Does your child have **urine accidents**? Specify daytime, nighttime, or both?
Y	**N**	20. Does your child have problems with **frequent or painful urination**? Specify:
Y	**N**	21. Does your child have any problems with **puberty? Menstruation if female?** Specify:
Y	**N**	22. Has your child ever had **tics or nervous twitches**, such as repeated eye blinking, head jerking, or throat clearing?
Y	**N**	23. Has your child had **seizures**? Specify:
Y	**N**	24. Has your child had any **difficulties with growth or his/her weight**? Any **special diets,** such as gluten/casein free? Specify:
Y	**N**	25. Does your child have any **birth defects** or **birthmarks**? Specify:
Y	**N**	26. Does your child have any problems with **rashes?** Specify:
Y	**N**	27. Does your child have any problems with **anemia, easy bruising, bleeding?** Specify:
Y	**N**	28. Does your child have any problems with their **muscles, bones, or joints?** Specify:
Y	**N**	29. Does your child have any problems with **frequent infections, or his/her immune system?** Specify:
		30. What is your child's **immunization status**? Check: ☐ Up to date ☐ Selected immunizations only ☐ Due for additional immunizations ☐ Not immunized

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Developmental-Behavioral Pediatrics
Parent Questionnaire

Child's Name (Last, First):

HISTORY: Prior Health Testing

Has your child had any of the following tests? Check those done. When? What were the results (if known)?

- ☐ MRI
- ☐ EEG
- ☐ Genetic Tests
- ☐ Hearing/Audiology Tests
- ☐ Vision Screen/Exam

HISTORY: Behavior

Y	**N**	1. Does your child have **many temper tantrums**?
Y	**N**	2. Did/Do you have **trouble keeping a babysitter** because of your child's behavior?
Y	**N**	3. Does your child often have **nightmares**?
Y	**N**	4. Does your child have any **problems falling asleep** at night? Specify:
Y	**N**	5. Does your child have any **problems staying asleep** through the night? Specify:
Y	**N**	6. Does your child have any **problems getting up** in the morning? Specify:
		7. At what time does your child **go to bed**?_____**fall asleep?**_____**wake up?** _____
Y	**N**	8. Does your child **snore** at night?
Y	**N**	9. Does your child often seem **tired or sleepy during the daytime**?
Y	**N**	10. Does your child have **problems with eating**? Specify:
Y	**N**	11. Does your child chew on or eat **non-food items** (such as toys, dirt/rocks, other objects)?
Y	**N**	12. Does your child have any **sensory sensitivity**, such as to sounds, touch, food textures? Specify:

HISTORY: Family Health

Is there anyone related to your child who has:				If yes, how is this person related to your child?
Y	**N**	**Don't Know**	1. ADHD / ADD (hyperactivity or attention problems)?	
Y	**N**	**Don't Know**	2. Alcohol problems?	
Y	**N**	**Don't Know**	3. Anxiety?	
Y	**N**	**Don't Know**	4. Autism Spectrum (e.g. Autism, Asperger, PDD-NOS)?	
Y	**N**	**Don't Know**	5. Bipolar Disorder / Manic Depression?	
Y	**N**	**Don't Know**	6. Heart problems before age 50 years or sudden death?	
Y	**N**	**Don't Know**	7. Delays in development or in speech/language?	
Y	**N**	**Don't Know**	8. Depression?	
Y	**N**	**Don't Know**	9. A History of physical or sexual abuse?	
Y	**N**	**Don't Know**	10. Learning or reading difficulty?	
Y	**N**	**Don't Know**	11. Mental Retardation or Intellectual Disability?	
Y	**N**	**Don't Know**	12. Neurologic problems?	
Y	**N**	**Don't Know**	13. Schizophrenia?	
Y	**N**	**Don't Know**	14. Seizures?	
Y	**N**	**Don't Know**	15. Tics or Tourette's disorder?	
Y	**N**	**Don't Know**	16. Receives/received special education when in school?	
Y	**N**	**Don't Know**	17. Receives/received services from the San Diego Regional Center?	
Y	**N**	**Don't Know**	18. Any of the above suspected but not diagnosed? Please explain:	
Y	**N**	**Don't Know**	19. Other diagnoses or health problems not listed above:	

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Developmental-Behavioral Pediatrics
Parent Questionnaire

Child's Name (Last, First):

HISTORY: Child's Past/Current Treatment

Y **N** 1. Has your child **had prior diagnoses by a professional**? If yes, which diagnoses? When? By whom?

☐ ADHD ☐ ADD ☐ Mental retardation/Intellectual disability
☐ Autism ☐ PDD-NOS ☐ Apraxia
☐ Asperger ☐ Learning Disorder ☐ Other
☐ Anxiety ☐ Depression
☐ Developmental Delay ☐ Cerebral Palsy

Y **N** 2. Has your child **ever taken medication for any of these concerns?**
If yes, do you know the **name**, **dose,** and **time(s) of day** the medication was given?

Name	**Dose**	**Time(s) of Day**	**Check if your child is currently taking this medication**
a.			☐
b.			☐
c.			☐
d.			☐

Y **N** 3. Were you **satisfied** with the medication's effect on your child's symptoms? Explain:

Y **N** 4. If medications were indicated for your child, would you be open to treatment with medication? Explain:

Y **N** 5. Are you hoping that there might be medication to address your child's concern? Explain:

6. **Which medication(s), including vitamins or herbal supplements, is your child currently taking?**

Name	**Dose**	**Time(s) of Day**
a.		
b.		
c.		
d.		
e.		

Are you **satisfied** with your child's current medication(s)? ☐ **Yes** ☐ **No** Explain:

7. **Are there any professionals (**such as doctors, psychiatrists, psychologists, social workers, occupational therapists, speech therapists, physical therapists, or other treatment professionals) **currently involved in your child's care? Please list them and their role in your child's care:**

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Developmental-Behavioral Pediatrics Parent Questionnaire

Child's Name (Last, First):

HISTORY: Child's Past/Current Services Please mark in the column which services your child has had or currently receives. Please provide details.

Services	Past	Current
504 Plan		
Applied Behavioral Analysis Therapy		
CA Early Start or other early intervention program		
Occupational Therapy		
Physical Therapy		
Regional Center		
School IEP *Eligible Under:* ☐ Speech Language Impaired ☐ Specific Learning Disability ☐ Mental Retardation/Intellectual Disability ☐ Other Health Impairment ☐ Autism ☐ Orthopedic Impairment ☐ Other (Specify):		
Social Skills Group/Training		
Special Education Preschool		
Speech/Language Therapy		
Other Therapy or Treatment. Please Specify:		

HISTORY: Changes or Stressors

Y	N	
Y	N	1. Have there been any **major changes or stresses** in your child's life? (Check all that apply): ☐ Marital Problems ☐ A Move ☐ Change of School ☐ Birth of a brother or sister ☐ Death of a pet ☐ Other If yes, please specify and include how old the child was at the time: Is this stress still occurring? ☐ Yes ☐ No
Y	N	2. Has there been a **serious illness or death** in a parent or close family member of your child? If yes, please specify and include how old the child was at the time:
Y	N	3. Are any **major changes or stresses** expected in the future? If yes, please specify:
Y	N	4. Has your child **experienced or seen any traumatic events** (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time: Is this trauma still occurring? ☐ Yes ☐ No

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Developmental-Behavioral Pediatrics Parent Questionnaire

Child's Name (Last, First):

HISTORY: Child's Living Arrangements

1. How would you describe the **current relationship** between your child's **biological parents**?

☐ Friendly / Amicable
☐ Unfriendly / Conflict ridden
☐ No relationship
☐ Not Applicable (please specify):
☐ Don't Know

2. Is your child adopted? ☐ Yes ☐ No If yes, does your child know that he/she is adopted? ☐ Yes ☐ No

Is your child in foster care? ☐ Yes ☐ No Explain:

Y	N	
		3. Are there any **immediate family members** who do not live with your child (biological mother, biological father, or siblings)? If yes, please specify relationship to child:

4. **Please list all people who are currently living in your child's household.**

Name	Relationship to Child	Age	Name	Relationship to Child	Age

5. Please list the **highest educational level** achieved by your child's biological parents:

Mother:
Father:

6. Please list the **job/occupation** of your child's biological parents:

Mother:
Father:

HISTORY: Military Family

Y	N	
		1. Are you or another parent/guardian of your child currently in the Military? If Yes, which branch? ☐ Navy ☐ Marine ☐ Air Force ☐ Army ☐ Other (specify):
		2. Are any of your child's parent(s)/guardian(s) Active Duty Military? If yes, who: ☐ Mother ☐ Father ☐ Both ☐ Other:
		3. Are they deployed or deployable? ☐ Yes ☐ No
		4. When did you PCS/Move to this Location? Date:
		5. When are you due to PCS / Move? Date:
		6. Is your child or other members of this family in the Exceptional Family Member Program?
		7. Is your child or other members of this family part of the Extended Health Care Option?

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Developmental-Behavioral Pediatrics
Parent Questionnaire

Child's Name (Last, First):

HISTORY: School Information

Child's Name:	Length of time at present school:	Current Grade:
Name of School:	School District:	
Teacher (main):	Principal:	School Phone:

1. Please describe your child's **strongest** areas in his/her **schoolwork**:	2.Please describe your child's **weakest** areas in his/her **schoolwork**:
a.	a.
b.	b.
c.	c.

HISTORY: School Intervention

Y	**N**	1. Has your child ever **repeated a grade**? If Yes, specify subject(s) / grade(s)?
Y	**N**	2. Has the school ever **discussed your child repeating a grade** with you? Specify:
Y	**N**	3. Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	**N**	4. Have any **disciplinary actions** been taken (detentions, suspension, or expulsion)? Specify:

HISTORY: School Problems

For each of the following grades your child has completed, were any **problems reported?** If Yes, please **describe** the teacher or parent concerns in the space provided.

			Academics	**Behavior**
Y	**N**	1. Preschool		
Y	**N**	2. Kindergarten and First Grade		
Y	**N**	3. Second and Third Grade		
Y	**N**	4. Fourth and Fifth Grade		
Y	**N**	5. Sixth through Eighth Grade		
Y	**N**	6. High School		

CURRENT: School Performance

Please circle the appropriate number.

	Above Average		**Average**		**Problematic**		**Above Average**		**Average**		**Problematic**
1. Classroom Assignment Completion	1	2	3	4	5	8. Science	1	2	3	4	5
2. Homework Completion	1	2	3	4	5	9. Written Expression	1	2	3	4	5
3. Getting Homework to and from school	1	2	3	4	5	10. Handwriting	1	2	3	4	5
4. Organizational Skills	1	2	3	4	5	11. Social Studies/History	1	2	3	4	5
5. Reading	1	2	3	4	5	12. Art	1	2	3	4	5
6. Spelling	1	2	3	4	5	13. Other:	1	2	3	4	5
7. Mathematics	1	2	3	4	5						

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Developmental-Behavioral Pediatrics Parent Questionnaire

Child's Name (Last, First):

Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior **NOT** on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
1. **Fails to give close attention** to detail or **makes careless mistakes** (e.g., homework).				
2. Has **difficulty attending** to what needs to be done.				
3. **Does not seem to listen** when spoken to directly.				
4. **Does not follow through** when given directions.				
5. Has **difficulties organizing** tasks and activities.				
6. **Avoids, dislikes**, or does not want to start tasks.				
7. **Loses things** necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by noises or other things.				
9. Is **forgetful** in daily activities.				
10. **Fidgets** with hands or feet or squirms in seat.				
11. **Leaves seat** when he/she is supposed to stay in seat.				
12. **Runs about or climbs** too much when he/she is supposed to stay seated.				
13. Has **difficulty playing** or starting quiet games.				
14. Is "**on the go**" or acts as if "driven by a motor".				
15. **Talks too much**.				
16. **Blurts out answers** before questions have been completed.				
17. Has **difficulty waiting his/her turn**.				
18. **Interrupts** or bothers others when they are talking or playing games.				
19. **Argues** with adults.				
20. **Loses temper**.				
21. Actively **disobeys or refuses** to follow adult's request or rules.				
22. **Bothers people** on purpose.				
23. **Blames others** for his or her mistakes or misbehaviors.				
24. Is **touchy or easily annoyed** by others.				
25. Is **angry or bitter**.				
26. Is **hateful** and wants to get even.				
27. **Bullies**, threatens, or scares others.				
28. **Starts physical fights**.				
29. **Lies** to get out of trouble or to avoid jobs (i.e. "cons" others).				
30. **Skips school** without permission.				
31. Is **physically unkind** to people.				
32. Has **stolen things** that have value.				
33. **Destroys others' property** on purpose.				
34. Has experimented with or abused **drugs or alcohol.**				

(OFFICE USE ONLY) 1—9: ____/9 Inattentive: □ ≥ 6 / 9 DuPaul: 10—18: ____/9 Hyperactive: □ ≥ 6 / 9 DuPaul: 19—26: ____/8 Oppositional Defiant Disorder: □ ≥ 4 / 8

Modified from the DuPaul ADHD Rating Scale and the Vanderbilt ADHD Diagnostic Parent Rating Scale by the Child and Adolescent Services Research Center (CASRC) in collaboration with the Children's Hospital and Health Center (CHHC) Committee on Guidelines for ADHD in Pediatrics (C-GAP) for use in the San Diego ADHD Project 2003.

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Developmental-Behavioral Pediatrics Parent Questionnaire

Child's Name (Last, First):

Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior **NOT** on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
35. Is physically **mean to animals**.				
36. Has **set fires** on purpose to cause damage.				
37. Has **broken into** someone else's home, business, or car.				
38. Has **stayed out all night** without permission or **runaway** from home overnight.				
39. Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).				
40. Is **fearful, anxious, or worried**.				
41. Is **afraid to try new things** for fear of making mistakes.				
42. Feels **useless or inferior**.				
43. **Blames self** for problems, feels at fault.				
44. Feels **lonely, unwanted, or unloved**; complains that "no one loves me."				
45. Is **sad or unhappy**.				
46. Feels **different and easily embarrassed**.				
47. Is **overly concerned about health/body**.				
48. Has problems getting along with **you**.				
49. Has problems getting along with **others his/her own age.**				
50. Has problems getting along with **his / her own siblings.**				
51. Has problems in **group activities** such as games or team play.				
52. **Decreased interest or pleasure in all**, or almost all, activities of the day.				
53. Has **said things like "I wish I were dead"** or has tried to hurt self.				
54. **Recurrent excessive distress** when separation from home or caretakers.				
55. Has **distinct periods of unusually irritable or unusually cheerful mood** (different from normal).				
56. Has **prolonged temper tantrums** (greater than 20-30 minutes).				
57. **Hears voices** others do not hear.				
58. Has **compulsions** (e.g. child seems driven to wash hands, count, erase until holes appear).				
59. Has **obsessions** (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
60. Has **recurrent recollections or dreams** of a traumatic event.				
61. Seems to **avoid or have phobias** of specific people, animals, things or situations.				
62. Seems **unaware of others existence**, is **uninterested in interacting with others**.				
63. Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness)				
64. Appears **uninterested in activities** children his or her age usually like or participate in.				

(OFFICE USE ONLY)
27—38: ____/12 Conduct Disorder: □ ≥ 3 / 12 **39—46**: ____/8 Anxiety/Depression: □ ≥ 3 / 8 **47—50**: ____/4 Social Functioning: □ ≥ 1 / 4 **51—64**: ____/14 Mental Health Concern

Modified from the DuPaul ADHD Rating Scale and the Vanderbilt ADHD Diagnostic Parent Rating Scale by the Child and Adolescent Services Research Center (CASRC) in collaboration with the Children's Hospital and Health Center (CHHC) Committee on Guidelines for ADHD in Pediatrics (C-GAP) for use in the San Diego ADHD Project 2003.

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Developmental-Behavioral Pediatrics
Parent Questionnaire

Child's Name (Last, First):

HISTORY: Summary

Please **summarize your child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings-- home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number.**

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
7	**Needs 24-hour <u>professional</u> care and supervision** due to severe behavior or gross impairment(s)

Is there anything else that you think would be helpful for the evaluation team to know? Please describe:

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Developmental-Behavioral Pediatrics
School Questionnaire

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Parents please be sure to write your child's full name and date of birth at the top of each page of this questionnaire

Child's Name: _____ Date of Birth: _____

Parent's Name: _____

The above-named child is being evaluated for attention, school, or behavior problems. As part of this comprehensive evaluation, we ask that you complete and return the following forms as soon as possible. **Please fill out the school-related forms detailed below and RETURN them promptly to the child's parents OR fax them directly to this child's doctor, DEVELOPMENTAL-BEHAVIORAL PEDIATRICS, at 858-496-9257.**

- School Questionnaire
- Teacher Questionnaire: Child Behavior
- Teacher Questionnaire: School Performance

If this child has more than one academic teacher, please make sure **two academic teachers** fill out the two Teacher Questionnaires (the school can copy the forms). **If this child is enrolled in summer school** have this child's summer school teacher complete the forms.

Please be as honest as possible in your responses. NOTE: Your comments are one part of a comprehensive evaluation; no diagnoses regarding this child will be made without input from several sources and without review by a trained clinician.

The parent / guardian of the above named child has signed the following consent form that allows you to release the requested information.

> MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Thank you for your concern and commitment to helping this child.

School Questionnaire

Child's Name: **Date of Birth:** **Sex: M F** **Today's Date:**

Person(s) completing form: Title/Position:

The above named child has been referred for evaluation. Since a large part of the child's day is spent in school, a description of the child's behavior and school environment will be extremely useful in our assessment. The parent / guardian of this child has signed the following consent form that allows you to release the requested information.

MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Name of School:		School District:		
Teacher (primary):		Principal:		
School FAX:		School Phone:		
School Address:		City:	State:	Zip:
Child's Current Grade:	Months/Years at present school:	School Type (public, private, etc.)**:**		
Indicate which school track this child is currently enrolled in: ____**Traditional** (Sept.-June) _____**Year-Round** _____**Summer School**				

CHIEF CONCERN

1. **How long** have teachers been concerned about this child?

2. What **concerns** do teachers have about this student?
   a.
   b.
   c.

3. Please describe this child's **strongest** areas in school:
   a.
   b.
   c.

4. Please describe this child's **weakest** areas in school:
   a.
   b.
   c.

HISTORY: School Intervention

Y	N	
Y	**N**	1. Has this child been in an **Early Intervention program**?
Y	**N**	2. Has this child had **speech, occupational or physical therapy**?
Y	**N**	3. Has this child **repeated a grade**? If Yes, which grade(s)?
Y	**N**	4. Has this child's **repeating a grade been discussed**? Specify:
Y	**N**	5. Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	**N**	6. Has this child received **any special education services**? Specify:
Y	**N**	7. Is this child **currently receiving any special education services**? Specify:
Y	**N**	8. Have any **disciplinary actions** been taken (suspension or expulsion)? Specify:

(OFFICE USE ONLY) concern **≥6 months:** Y N **School Intervention:** Y N

HISTORY: School Problems Reported

For each of the following grades this child has completed, were any **problems reported**? If Yes, please **describe** the concerns in the space provided.

			Academics	**Behavior**
Y	**N**	Preschool		
Y	**N**	Kindergarten		
Y	**N**	First grade		
Y	**N**	Second grade		
Y	**N**	Third grade		
Y	**N**	Fourth and fifth grade		
Y	**N**	Sixth through eighth grade		
Y	**N**	High school		

HISTORY: Testing

Please list any Aptitude/Psychological or Achievement/Academic tests administered to this child (Please send copies of diagnostic testing results so that we do not duplicate testing).

Name of Test (no abbreviations, please)	Date Given	Grade/Year	Results
a.			
b.			
c.			
d.			

****Please attach any standardized testing, report cards, school study team summaries or IEP results available for this student.****

(OFFICE USE ONLY) **Academic School Performance:** Y N **Behavior School Performance:** Y N **Tests:** Y N

Child's Name: **Date of Birth:**

TEACHER QUESTIONNAIRE: Child Behavior (cont'd)

Check the box that best describes this child's behavior over the past 6 months. *If child is on medication, please rate child's behavior **NOT** on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
1. **Fails to give close attention** to details or **makes careless mistakes** in schoolwork.				
2. Has **difficulty sustaining attention** in tasks or activities.				
3. **Does not listen** when spoken to directly.				
4. **Does not follow through** on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand).				
5. Has **difficulties organizing** tasks and activities.				
6. Avoids, dislikes, or is **reluctant to engage in tasks** that require sustained mental effort.				
7. **Loses things** necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by extraneous stimuli.				
9. Is **forgetful** in daily activities.				
10. **Fidgets** with hands or feet or squirms in seat.				
11. **Leaves seat** in classroom or in other situations in which remaining seated is expected.				
12. **Runs about or climbs excessively** in situations in which remaining seated is expected.				
13. Has **difficulty playing** or engaging in leisure activities quietly.				
14. Is **"on the go"** or acts as if "driven by a motor."				
15. **Talks excessively.**				
16. **Blurts out answers** before questions have been completed.				
17. Has **difficulty waiting in line**.				
18. **Interrupts** or intrudes on others (e.g. butts into conversations or games). 19. **Loses temper**.				
20. Actively **defies or refuses** to comply with adult's request or rules.				
21. Is **angry or resentful**.				
22. Is **spiteful** and **vindictive.**				
23. **Bullies**, threatens, or scares others.				
24. **Initiates physical fights**.				
25. **Lies** to obtain goods for favors or to avoid obligations (i.e. "cons" others).				
26. Is **physically cruel** to people.				
27. Has **stolen items of nontrivial value.**				
28. Deliberately **destroys others' property.**				

(OFFICE USE ONLY) 1--9: **/ 9** Inattentive: > 6 / 9 DuPaul: 10--18:____/ 9 Hyperactive: > 6 / 9 DuPaul: 19--28:____/ 10 Oppositional Defiant Disorder / Conduct Disorder: > 3 / 10

Child's Name: **Date of Birth:**

Check the box that best describes the child's behavior over the past 6 months. *If the child is currently taking medication, please rate the child's behavior **NOT** on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
29. Is **fearful, anxious, or worried.**				
30. Is **self-conscious** or easily embarrassed.				
31. Is **afraid to try new things** for fear of making mistakes.				
32. Feels **worthless or inferior**.				
33. **Blames self** for problems, feels guilty.				
34. Feels **lonely, unwanted, or unloved**; complains that "no one loves me."				
35. Is **sad, unhappy, or depressed**.				
36. Is physically **mean to animals**.				
37. **Skips school** without permission.				
38. Has **set fires** on purpose to cause damage.				
39. Has **broken into** someone else's home, business, or car.				
40. Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).				
41. Has **said things like "I wish I were dead"** or has tried to hurt self.				
42. Has **distinct periods where mood is unusually irritable OR unusually good, cheerful, or high** which is clearly excessive or different from normal mood.				
43. Seems to have **compulsions** (repetitive behaviors that this child seems driven to carry out, such as repeated hand washing, counting, or erasing until holes appear).				
44. Seems to have **obsessions** (persistent or repetitive thoughts that distress this child, such as worry about germs or doors left unlocked).				
45. **Has prolonged temper tantrums** (greater than 20-30 minutes).				
46. **Hears voices** telling the child to do bad things.				
47. Seems **unaware of others existence**, is **uninterested in interacting with others**.				
48. Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness).				
49. Appears **uninterested in activities** children his or her age usually like or participate in.				
50. Does this child's **educational placement** seem appropriate? Comments:			**Y**	**N**
51. Do this child's **parent(s) appear to be invested** in this child's academic success? Comments:			**Y**	**N**
52. Does this child seem **motivated** to learn? Comments:			**Y**	**N**
53 a. Is this child on **medication** for ADHD? **(if yes, please answer 53b- 53e)**		**Don't Know**	**Y**	**N**
b. Do you know the **name of the medication and when the child takes it**?			**Y**	**N**
c. If yes, **Medication:** **Times of day** child takes medication (specify am/pm):				
d. Do you believe **medication is helping** this child? Comments:			**Y**	**N**
e. Does the medication seem to work **all school day**? Comments			**Y**	**N**

(OFFICE USE ONLY) 29—35: ___ / 7 Anxiety/Depression: > 3 / 7 36—49: ___ / 14 Mental Health Concerns 50. Education Placement: Y N 51. Invested: Y N 52. Motivation: Y N

TEACHER QUESTIONNAIRE: School Performance

Child's Name:

Person(s) completing form: Subject / Time of Class:

Telephone Number: FAX Number:

TEACHERS: For students in Kindergarten through High School, please completely fill out the rest of the packet.

CURRENT: Classroom Behavior

Please check the appropriate box	Above Average		Average		Problematic
1. Understanding verbal instructions	1	2	3	4	5
2. Classroom assignment completion	1	2	3	4	5
3. Organizational skills	1	2	3	4	5
4. Getting homework to and from school	1	2	3	4	5
5. Homework completion	1	2	3	4	5
6. Relationship with peers	1	2	3	4	5
7. Following directions	1	2	3	4	5
8. Disrupting class	1	2	3	4	5
9. Verbal participation in class	1	2	3	4	5

CURRENT: School Performance

Please check the appropriate box	Above Average		Average		Problematic
1. Reading decoding	1	2	3	4	5
2. Reading comprehension	1	2	3	4	5
3. Reading rate/fluency	1	2	3	4	5
4. Spelling accuracy	1	2	3	4	5
5. Mathematics concepts	1	2	3	4	5
6. Mathematics computation	1	2	3	4	5
7. Handwriting	1	2	3	4	5
8. Writing rate	1	2	3	4	5
9. Punctuation/grammar	1	2	3	4	5
10. Ability to express thoughts through writing	1	2	3	4	5
11. Gross motor skills	1	2	3	4	5
12. Fine motor skills (using pencil & scissors)	1	2	3	4	5

CURRENT: Summary

Please **summarize this child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare this child's functioning in 2 settings--at school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number.**

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
7	**Needs 24-hour <u>professional</u> care and supervision** due to severe behavior or gross impairment(s)

(OFFICE USE ONLY) Behavior: Y N School Performance: Y N Impairment > 4: Y N

TEACHER QUESTIONNAIRE: School Performance *(continued)*

HISTORY: Learning Problems

We are interested in whether or not this child has learning problems **above and beyond** what would be expected for **his or her developmental age**.

Check the box that best describes the child's learning problems over the past 6 months.	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
1. Has trouble **learning new material** in an appropriate time frame for age and skills.				
2. Has little **desire to master** new skills.				
3. **Unable to tell time,** days of the week, months of the year.				
4. Can't **repeat information**.				
5. **Knows material one day; doesn't know it the next**.				
6. Has trouble **holding several different things in mind** while working.				
7. Has trouble **following multi-step directions**.				
8. Has difficulty **copying written material** from blackboard.				
9. Difficulty **orienting self** (i.e., gets lost, can't find way, or gets turned around easily).				
10. Has poor **spatial judgment** and often bumps into things.				
11. Confuses **directionality** (up/down, left/right, over/under).				
12. Has poor **spatial organization** on paper (difficulty staying in lines, maintaining space between words, staying within page margins).				
13. **Mixes up capital and lower** case letters when writing.				
14. **Reverses letters and numbers.**				
15. Has trouble **expressing words** or events in **correct order**.				
16. Often **mispronounces known or familiar words** or uses wrong word.				
17. Has trouble **verbally expressing thoughts**.				
18. Says things that have **little or no connection to what others are discussing**.				
19. Has difficulty **distinguishing long vowel sounds and short vowel sounds**.				
20. Depends on teacher or others for **repetition of task instructions**.				
21. Displays **poor word attack skills** (can't sound out words).				
22. Puts wrong **number of letters in words**.				
23. **Confuses consonant sounds**, for example: d-b, d-t, m-n, p-b, f-v, s-z.				
24. Unable to **keep place on page** when reading.				

Do you have any **additional comments** that you think would be helpful?

(OFFICE USE ONLY) **1—8:** / 8 General: > 4 / 8 **9—14:** / 6 Visual/Spatial Processing: > 3 / 6 **15—20:** / 6 Language: > 3 / 6 **21—24:** / 4 Reading/Writing: > 2/4

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