# PATIENT QUESTIONNAIRE

**Please fill out the following questionnaire** to help us better understand the patient, AND **bring it with you to the appointment**.

Date:_____

**CHILD/Patient NAME:**_____Age:_____ **Birth Date:** _____
Address:_____
Name of Person Completing this form:_____Relationship:_____
Primary Care Doctor:_____ Telephone:_____
Doctor's Address:_____

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A. What concerns do you have about your child that prompted a referral to the MIND Institute and what are your goals for this evaluation? ❒ Diagnosis ❒ Recommendations for medical/ medication interventions ❒ Other: *please explain*: _____
_____

**CURRENT FAMILY SITUATION:**

**Caregiver #1** Name:_____ Age:_____ Ethnic/Cultural Background: _____
Relationship to child: Mother ❒ Father ❒ Step-Parent ❒ Adoptive Parent ❒ Foster Parent ❒ Other_____
Home Address:_____
Phone (Primary):_____ Phone (Secondary):_____Email: _____
Occupation:_____ Highest Education Level: _____

**Caregiver # 2** Name:_____ Age:_____ Ethnic/Cultural Background: _____
Relationship to child: Mother ❒ Father ❒ Step-Parent ❒ Adoptive Parent ❒ Foster Parent ❒ Other_____
Home Address:_____
Phone (Primary):_____ Phone (Secondary):_____Email:_____
Occupation:_____ Highest Education Level_____

**With which caregiver(s) does the child live?** Both ❒ Mother ❒ Father ❒ Other(s)_____
If parents are separated/divorced, who has custody of the child?_____How often does the other parent see this child?_____
Primary language spoken in your home?_____ Other languages child is exposed to?_____
Do any other adults live in the home? Yes ❒ No ❒ Name/age/relationship (please indicate): _____
How many children are living in the home? _____Ages (indicate if step-sibling or foster siblings):_____

**EVALUATION AND TREATMENT HISTORY**

Has your child ever been evaluated for medical, developmental, behavioral, emotional or learning problems? Check all that apply.
Previous treatment/evaluations/diagnostic tests: (*Please provide a copy of reports – or provider name, date, and summary of* findings)

❒ Developmental pediatrician ❒ Physical/ Occupational Therapy ❒ Mental Health Therapist/Counselor
❒ Medical doctor/specialist ❒ Early intervention services ❒ Psychologist ❒ Regional Center
❒ Neurologist ❒ Behaviorist/ ABA therapy ❒ School district ❒ In-home support
❒ Psychiatrist ❒ Speech-Language Therapist ❒ Other (specify): _____

Please list agencies/intervention services currently involved with your family (e.g. Regional Center, Healthy Start, Child Protective Services, Early Intervention, speech therapy, OT, PT, ABA, etc). Include names of contact persons and phone numbers if known: ____
_____

**Diagnostic tests:** (*dates and results, if known*)

❒ Audiology Evaluation_____ ❒ EEG (brain wave test)_____ ❒ Head Ultrasound_____
❒ Ophthalmology Evaluation_____ ❒ MRI _____ ❒ Genetic/Chromosomal/DNA testing_____
❒ Sleep study _____ ❒ CT Scan _____ ❒ Blood test (other than routine blood count) _____
❒ Other (specify) _____

**Has your child been given a specific diagnosis? I**f yes, please check below or specify: _____

❒ Learning disability ❒ ADHD ❒ Autism/Asperger's/PDD ❒ Speech/Language disorder
❒ Epilepsy ❒ Sensory integration ❒ Motor delay ❒ Cerebral Palsy
❒ Fragile X ❒ Tourette's/ tics ❒ Developmental Delay ❒ Behavior/emotional disorder
❒ Intellectual Disability ❒ Genetic syndrome:_____ ❒ Other:_____

**PREGNANCY**

Was there prenatal care during the pregnancy? Yes ❒ No ❒ Starting in which month _____Mother's age during pregnancy_____
Previous pregnancies? Yes ❒ (if yes, number of pregnancies, including miscarriages) _____
❒ Were any medications (specify) or other methods used to assist with becoming pregnant? _____

## PATIENT QUESTIONNAIRE

Did mother have any of the following during or immediately before/after the pregnancy? (Please check all that apply)
❒ Infections ❒ Anemia ❒ Diabetes ❒ Vaginal bleeding ❒ Bed-rest ❒ High blood pressure
❒ Threatened miscarriage ❒ Emotional problems ❒ Other (Rh incompatibility, etc.)
❒ Hospitalization during pregnancy? Reason:_____ ❒ X-rays during pregnancy? What month? _____
❒ Medications prescribed during the pregnancy. Please list:_____
Were any of the following used during this pregnancy? (Please check all that apply)
❒ Tobacco ❒ Alcohol ❒ Marijuana ❒ Methamphetamines ❒ Cocaine/Crack ❒ Heroin ❒ Methadone ❒ Other (specify)_____

**BIRTH HISTORY:**
Name of hospital and location where infant was born? _____Was infant born full term: No ❒ Yes ❒
Weeks Gestation: _____ Birth weight:_____lbs. _____oz. Length:_____
Type of delivery: ❒ Spontaneous ❒ Cesarean ❒ Induced (e.g. Pitocin) ❒ Twins/Multiple
❒ Head first ❒ Breech (feet first) ❒ with instruments (e.g. forceps/vacuum)
Infant's APGAR scores (if known): 1 minute_____ 5 minutes _____
Describe any complications during or after delivery:_____
Length of stay in hospital: Mother: _____ days Infant: _____ days
Did infant require supplemental oxygen? No ❒ Yes ❒ If yes, how long:_____
Was infant placed in the NICU? No ❒ Yes ❒ If yes, how long:_____
Did infant pass newborn hearing screening? No ❒ Yes ❒ Bilirubin lights (for jaundice) No ❒ Yes ❒
Did infant have seizures? No ❒ Yes ❒ Did infant have abnormal head ultrasound/scan? No ❒ Yes ❒
Did infant require blood transfusions? No ❒ Yes ❒ Did infant require surgery? No ❒ Yes ❒

**DEVELOPMENTAL HISTORY**:
**Cognitive Development:**
Do you believe your child's ability to think or learn is delayed?No ❒ Yes ❒ How old does your child seem to act to you?_____

**Motor Development**: (please give age each occurred)
Age Sat alone:_____ Age Crawled: _____ Age Walked:_____
Gross Motor Delay: No ❒ Yes ❒ Clumsy/uncoordinated: No ❒ Yes ❒
Fine Motor Delay: No ❒ Yes❒ Problems with handwriting: No ❒ Yes ❒ Problems buttoning/tying shoes: No ❒ Yes ❒
Which hand/leg does your child use for: Writing/Drawing? _____ Eating?_____ Kicking:_____

**Speech and Language**: (please give age each occurred)
Age spoke single words: _____ Age spoke in 3-word phrases:_____ Difficulty saying words/pronunciation? Yes ❒ No ❒
How does your child communicate now?: Signs/Pictures ❒ Single words ❒ Phrases/Short sentences ❒ Lengthy Sentences ❒
How much does child comprehend: Gestures/signs ❒ One-stepped directions ❒ Two-stepped directions ❒ No concerns ❒
Hearing concerns: Yes ❒ No ❒ Hearing tested? (Date & results)_____Wears Hearing Aide?: Yes ❒ No ❒

**Adaptive Skills**:
Toilet Trained: Bowel No ❒ Yes ❒ At what age:_____ Bladder No ❒ Yes ❒ At what age:_____ Accidents after training?____
Eating Behavior: ❒ Normal ❒ Picky/Restrictive diet ❒ Gagging ❒ Weight loss/gain

Sleep Behavior: ❒ No Problems ❒ Nighttime waking ❒ Problems falling asleep ❒ Bedwetting ❒ Loud snoring
Has child ever lost skills which at one time he/she was able to perform? Yes ❒ No ❒ If yes, please explain:_____
_____

**Social Skills**:
Does child make good eye contact? ..... Yes ❒ No ❒
Point to show you things? ..... Yes ❒ No ❒
Seek out your attention for play/fun? ..... Yes ❒ No ❒
Likes to play with other children? ..... Yes ❒ No ❒
Poor social skills compared to same age peers? ..... Yes ❒ No ❒
More interested in things than people? ..... Yes ❒ No ❒
Prefers playing with children, other than siblings, who are older, younger, or same age? _____ Number of friends_____

**Sensory Behaviors:**
Touch/ Textures…… Avoids ❒ Seeks out ❒ Specify: _____
Sight…… Avoids ❒ Seeks out ❒ Specify: _____
Smell…… Avoids ❒ Seeks out ❒ Specify: _____
Tastes…… Avoids ❒ Seeks out ❒ Specify: _____
Sounds …… Avoids ❒ Seeks out ❒ Specify: _____

# PATIENT QUESTIONNAIRE

**Current Behavior:**

Please indicate whether your child has any of the following behaviors that are a problem. (Check all that apply)

❒ Short attention span/Distractible ❒ Oppositional/Defiant ❒ Unable to separate from parent ❒ Classroom disruption
❒ Impulsive/Overactive ❒ Peer conflicts ❒ Requires a lot of parental attention ❒ Poor school work
❒ Daydreaming ❒ Anxious/worries/fears ❒ Rocking/spinning/hand flapping ❒ Mean to others/bullying
❒ Doesn't follow directions ❒ Panic Attacks ❒ Depressed ❒ Low self-esteem
❒ Easily frustrated/ Agitated ❒ Sexualized behavior ❒ Isolated/withdrawn ❒ Self-injurious (head bangs, bites/hits self)
❒ Aggressive/Destructive ❒ Strange behavior/thoughts ❒ Suicide thoughts ❒ Drug/Alcohol use
❒ Other: Please describe any other behaviors of concern:_____

**Behavior Management Methods:**

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?
❒ Time out ❒ Loss of privileges ❒ Verbal Redirection ❒ Grounding ❒ Yelling ❒ Physical Discipline/spanking
❒Other (specify)_____Who is mainly in charge of discipline?_____
What do you find most difficult about raising your child?_____

**Family Changes/Stressors:** Has this child ever experienced any of the following?

❒ Marital discord/separation/divorce ❒ Parent deployed overseas/out of town for work extensively ❒ Living away from parent
❒ Birth/Adoption of another child ❒ Financial problems ❒ Sibling/parent illness (severe or death) ❒ Parent legal problems
❒ Parent emotionally/mentally ill ❒ Parents disagree about child rearing ❒ Witness physical violence ❒ Homelessness
❒ Other significant trauma/negative event ❒ Involved in juvenile court ❒ Involved with Social Services/Child Protective Services
What are the major family stressors at the present time, if any?_____

**MEDICAL HISTORY**:

**Does child have any allergies to medication/food? Yes ❒ No ❒ If yes, please list:**_____
Is child up to date on immunizations? No ❒ Yes ❒ If no, which are missing?_____
Any negative reactions to immunizations? No ❒ Yes ❒ Describe:_____

Has child ever lost consciousness? No ❒ Yes ❒ if yes, please explain:_____
Accidents/Injuries: Age:_____Type (head, abdomen, fracture, etc.):_____
Surgery/Operations: Age: _____Reason:_____ Where:_____
Hospitalizations/ER visits: Age: _____Reason:_____Where:_____

Date of: Last Vision screening?_____ Passed? Yes ❒ No ❒ Last Hearing screening?_____ Passed? Yes ❒ No ❒
**Does child need eye glasses or assistive hearing devices**: _____

Has child had any medical problems affecting the systems or organs listed below?

| System/Organ | | | Please explain |
|---|---|---|---|
| Eyes | Yes ❒ | No ❒ | |
| Ears, nose, throat | Yes ❒ | No ❒ | |
| Heart | Yes ❒ | No ❒ | |
| Lungs | Yes ❒ | No ❒ | |
| Digestive ((esophagus, stomach, intestines) | Yes ❒ | No ❒ | |
| Kidneys/urinary | Yes ❒ | No ❒ | |
| Endocrine (hormones, glands) | Yes ❒ | No ❒ | |
| Skin | Yes ❒ | No ❒ | |
| Blood | Yes ❒ | No ❒ | |
| Neurologic (brain, spinal cord, trauma, seizures) | Yes ❒ | No ❒ | |
| Psychiatric/Emotional | Yes ❒ | No ❒ | |

**Medication(s):**

Does your child take any medication: Yes ❒ No ❒ If more, please attach additional sheet of paper.

| | Medication #1 | Medication #2 | Medication #3 |
|---|---|---|---|
| DRUG NAME and DOSE | | | |
| PRESCRIBED BY WHOM: | | | |
| FOR WHAT PROBLEMS: | | | |
| DATE STARTED / STOPPED: | | | |
| BENEFITS: | | | |
| SIDE EFFECTS: | | | |

Past Medications: _____

# PATIENT QUESTIONNAIRE

**FAMILY MEDICAL HISTORY:**

**Mother**: Health, learning, mental health problems? (Please specify):_____

_____

**Father:** Health, learning, mental health problems? (Please specify):_____

_____

**Siblings (Half-siblings):** Health, learning, mental health problems? (Please specify): _____

_____

Have any extended family members had the following problems/disorders? (Please specify who)

| | | |
|---|---|---|
| ❒ Birth defect | ❒ Obsessive Compulsive Disorder | ❒ ADHD |
| ❒ Cerebral palsy | ❒ Anxiety/nervousness | ❒ Reading problem/Dyslexia |
| ❒ Chromosomal/genetic disorder | ❒ Tics/Tourette syndrome | ❒ Other Learning Disabilities:_____ |
| ❒ Alzheimer's disease | ❒ Bipolar/manic-depressive disorder | ❒ Speech/language delay |
| ❒ Parkinson's disease | ❒ Emotional disturbance | ❒ Developmental delay |
| ❒ Movement Disorder | ❒ Depression | ❒ Intellectual disability/Cognitive delay |
| ❒ Seizures or epilepsy | ❒ Schizophrenia/Psychosis | ❒ Autism/PDD/Asperger |
| ❒ Autoimmune disorder: _____ | ❒ Antisocial behavior syndrome (Assaults, thefts, arrests) | |
| ❒ Alcohol/drug abuse | ❒ Childhood behavior disorder (Aggressive/defiant/oppositional) | |

❒ Other:_____

Have any family members ever received extra help in school, early intervention, or special education services? Yes ❒ No ❒

If yes, please specify reason? _____

**CHILD'S EDUCATIONAL HISTORY:**

Name of current school:_____City/State:_____ Phone Number:_____

Grade: _____Teacher's name:_____

**Intervention/School History**:

| | | |
|---|---|---|
| Early Intervention/In-home (0-3 years)? | School/program name:_____ | Age? _____ |
| Preschool/Head Start? | School/program name:_____ | Age/Grades?_____ |
| Elementary school? | School/program name:_____ | Age/Grades?_____ |
| Middle school? | School/program name:_____ | Age/Grades?_____ |
| High School? | School/program name:_____ | Age/Grades?_____ |

Has child ever repeated a grade? No ❒ Yes ❒ if yes, what grade:_____

Does child like going to school? No ❒ Yes ❒

Has child ever been suspended or expelled? No ❒ Yes ❒ Reason:_____

Is child late or absent from school frequently? No ❒ Yes ❒ Reason:_____

Are there other concerns about your child's learning or behavior?_____

**School Assessments and Intervention**:

Has child had special education testing in school?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Psychological/Cognitive | No ❒ | Yes ❒ | Date:_____ | Occupational Therapy: | No ❒ | Yes ❒ | Date:_____ |
| Speech/Language | No ❒ | Yes ❒ | Date:_____ | Physical Therapy: | No ❒ | Yes ❒ | Date:_____ |
| Academic (RSP) | No ❒ | Yes ❒ | Date:_____ | Other: | No ❒ | Yes ❒ | Date:_____ |

Is your child on an IEP (Individual Education Plan) or IFSP? No ❒ Yes ❒ Reason?_____

**CHILD'S STRENGTHS**:

Please tell us what activities your child likes or does well. What do you enjoy most about your child? _____

_____

_____

## Thank you for sharing this important information.

**Please bring this questionnaire, all evaluation reports, and school records/IEP with you to your appointment:**

**MIND Institute- Massie Family Clinic**
**UC Davis Health System**
**2825 50th Street Sacramento, CA 95817 916.703.0308**

***Or Fax to 916. 703.0305***