

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: _____

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? At what age? 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? _____

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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 Opioids 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: _____

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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 <input type="checkbox"/>	No <input type="checkbox"/>	_____
Ears, nose, throat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heart	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Lungs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Digestive ((esophagus, stomach, intestines)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Kidneys/urinary	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Endocrine (hormones, glands)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Skin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Blood	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Neurologic (brain, spinal cord, trauma, seizures)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Psychiatric/Emotional	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

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: _____

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

Have any family members ever received extra help in school, early intervention, or special education services? Yes No
If yes, please specify who and reason for intervention? _____

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:

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