Parent/guardian Questionnaire

Developmental Pediatrics Clinic
Children's Hospitals and Clinics of Minnesota

We appreciate you taking the time to fill out this questionnaire. This information will help us plan the evaluation for your child. Please return as soon as possible. If you would like help completing this form, please call 612-813-6777. **Please use blue or black pen when filling out this form.**

Date: _____

Patient's Name: _____Date of Birth: _____Sex: ☐Male ☐Female

Form completed by: _____ Relationship to child: _____

Reason for referral

What are your main concerns about your child? *Please check all that apply.*

☐Ability to interact with others
☐Attention
☐Behaviors
☐Communication
☐Coordination (ex: walking, running, sports)
☐Learning Delays
☐Repetitive movements (ex: hand flapping, hand wringing, eye twitching, etc.)
☐Self help skills (ex: toileting, bathing, dressing, using utensils, feeding, etc.)
☐Self injurious behaviors (ex: hitting self, banging head)
☐Writing or drawing
☐Other: _____

What do you hope to accomplish during this visit?

_____
_____
_____

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Pregnancy/birth history

During the pregnancy with this child, did the child's mother:	Yes	No	Comments:
See a doctor regularly?			Date of first prenatal visit?
Take any prescribed medications?			
Drink any alcoholic beverages?			How much?
Take any street drugs?			What type?
Smoke?			How much per day?
Vomit frequently?			
Have any severe accidents?			
Have any infectious diseases or rashes?			
Have any x-rays?			
Have high blood pressure?			
Have any other medical problems?			
Have any pregnancies prior to this child's birth?			How many?

Mother's age at the time of birth: _____

What was the child's birth weight? _____lbs _____oz

Type of delivery:
☐Vaginal
☐Scheduled Caesarean
☐Emergency Caesarean
☐Forceps/Vacuum

Was the child born on time? ☐Yes ☐No How many weeks were they at birth? _____

Where was the child delivered? _____

Were there any problems during or after the child's birth?_____
_____
_____
_____

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Medical History

Has your child ever:	Yes	No	Date:	Reason /Results
Had a hearing test?				
Had a vision test?				
Been hospitalized?				
Had surgery?				
Had a previous developmental assessment?				
Had a sleep study?				
Had seizures?				
Had a head injury?				
Had an EEG?				
Had an MRI?				
Had previous diagnostic testing?				
Other?				

Describe any concerns above, especially if it is a current concern:

_____

_____

_____

Does your child see:	Yes	No	Name of Provider/Physician	Location
Genetics				
Neurology				
Physical medicine				
Psychology/psychiatry				
Rehabilitation (i.e. speech, occupational or physical therapy)				
Early intervention				
Other				

Development

Please give information on the following milestones:

When did your child begin to… (best memory is okay)	Age	Comments
Sit independently?		
Walk?		
Point/Show objects to others?		
Use clear words?		
Combine words?		
Pretend/imaginary play?		
Be toilet trained in daytime?		

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Family and social history

Parent's Name: _____ Occupation: _____

Parent's Name: _____ Occupation: _____

Are parents in a relationship? ☐Yes ☐No Are parents: ☐Separated? ☐Divorced? ☐Married?

Legal guardian(s) of child: _____ Relationship: _____

Circle One: Adopted Natural Foster

What is the primary language spoken at home?
☐English ☐Spanish ☐Somali ☐Other: _____

What is the child's primary language?
☐English ☐Spanish ☐Somali ☐Other: _____

Who currently lives in the home? (Including foster brothers and sisters and those living part-time with the family)
_____
_____

Who is the child's primary caregiver? _____

Has your child/children ever lived outside of your home or away from you for any period of time? ☐Yes ☐No

If so, when? _____ With whom? _____

Please complete the chart below for brothers and sisters of child (include half brothers and sisters):

Name	Age	Relationship	Developmental/learning (normal/advanced/delayed)	List any diagnoses

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Please check the boxes if any of the **CHILD'S** relatives have had any of the following conditions:

Conditions	Siblings	Mother	Mother's Mother	Mother's Father	Father	Father's Mother	Father's Father
ADHD							
Allergy							
Asthma							
Autism							
Behavior problems							
Birth defects							
Blood disorders							
Cancer							
Cerebral palsy							
Developmental Delay							
Diabetes – Type 1							
Diabetes – Type 2							
Emotional Problems							
Genetic disorders							
Heart problems							
Impaired Hearing							
Impaired Vision							
Language Development Disorder							
Mental disorders							
Muscle disorders							
School problems							
Seizures							
Speech problems							
Thyroid disease							

Describe any marked answers from above:

_____

_____

_____

_____

Thank you for filling out this questionnaire.
Please return it in the enclosed envelope or mailed to the address below:

Developmental Pediatric Clinic
Children's Hospitals and Clinics of Minnesota
2525 Chicago Avenue South, CSC-390
Minneapolis, MN 55404