Kaiser Permanente Santa Clara Medical Center
Department of Pediatrics
710 Lawrence Expressway #190
Santa Clara, CA 95051
(408) 851-9897

Dear Parent (or Caretaker):

Your child has been referred for a developmental pediatrics evaluation. This is because you, or your physician, have expressed some concerns about your child's progress in one or more areas of development, such as speech and language, walking and motor skills, school performance, or behavior.

This evaluation will be done by our developmental pediatrician. It will usually be completed in one visit, but sometimes a follow-up visit may be needed.

The developmental evaluation involves asking parents or caretakers a series of questions about what the child does and does not do, as well as directly observing the child during play and in a series of testing situations. Because time is limited, we would appreciate your filling out this Child Development Questionnaire to provide additional information.

If you don't know the answer to any question, write "Unknown." If a question does not apply to your child, write "N/A." If there are some things you would prefer discussing in person with the developmental pediatrician, just note that on the form.

Thank you for helping us to provide the best care for your family.

Please bring the completed questionnaire to your appointment with the developmental pediatrician.

KAISER PERMANENTE®

MR #:
Name:

# CHILD DEVELOPMENT QUESTIONNAIRE

| CHILD'S FULL NAME | KAISER PERMANENTE MRN NO | CHILD'S BIRTH DATE | TODAY'S DATE |
|---|---|---|---|
| NAME OF PERSON(S) COMPLETING THIS FORM | RELATIONSHIP TO CHILD | | |
| WHAT DOES YOUR CHILD LIKE TO BE CALLED? | CHILD'S SCHOOL (OR PRESCHOOL) | GRADE | |
| FATHER'S NAME | (CIRCLE ONE): Biological Adoptive Stepfather | | |
| AGE SCHOOL LEVEL COMPLETED | EMPLOYMENT | ETHNIC BACKGROUND (OPTIONAL): | |
| MOTHER'S NAME | (CIRCLE ONE): Biological Adoptive Stepmother | | |
| AGE SCHOOL LEVEL COMPLETED | EMPLOYMENT | ETHNIC BACKGROUND (OPTIONAL): | |
| LANGUAGES SPOKEN AT HOME (CIRCLE): English Spanish Other (PLEASE SPECIFY): | | | |
| CURRENT MARITAL STATUS OF PARENTS (CIRCLE): Married Separated Divorced Living together Other (PLEASE SPECIFY): | | | |
| WITH WHOM DOES THE CHILD LIVE? | | | |
| CONTACT PERSON: PHONE NUMBERS: HOME | WORK | CELL | |

**Please list the concerns you have about your child.**
If you do not have any concerns about your child's development or behavior, check here:

| Problem | Age noted | Diagnosis (if known) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Is your child receiving services from Early Start or the Regional Center? Y/N

If yes, **please bring any related paperwork to the Pediatric Development Clinic visit.**

Please list your child's **strengths/best qualities:**

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

**CHILD'S SIBLINGS:**

| Sibling's full name | Date of birth | Health or developmental problems? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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# CHILD DEVELOPMENT QUESTIONNAIRE

**MOTHER'S PRENATAL HISTORY:**

If the child's mother is not completing this form, please provide as much information as possible.

| | Y | N |
|---|---|---|
| Did you smoke cigarettes during this pregnancy? | □ | □ |
| Did you drink alcohol before and/or during this pregnancy? | □ | □ |
| Were there any health problems during the pregnancy? | □ | □ |
| Did you take any medications during the pregnancy? | □ | □ |
| Was the child born within two weeks of your due date? | □ | □ |
| Were there any problems with the delivery? | □ | □ |

Where was the child born (what country, what hospital)?______________________________________

**YOUR CHILD'S BIRTH:**

Include as much information as you know.

Birth weight:______________ Apgar scores: _____________ Delivery (circle): Vaginal / C-section

| | Y | N |
|---|---|---|
| Baby breathed immediately | □ | □ |
| Baby cried immediately | □ | □ |
| Required any treatment in delivery room | □ | □ |
| Was in NICU (Intensive care) | □ | □ |

How many days did baby stay in the hospital? _______________

**YOUR CHILD'S HEALTH:**

| | Y | N | |
|---|---|---|---|
| Any hospital admissions? | □ | □ | If yes, give age and problem: ______________________________ |
| Any surgeries? | □ | □ | If yes, give age and type of surgery: ______________________ |
| Ever had brain imaging? | □ | □ | If yes, give age and reason: ________________________________ |
| History of trauma? | □ | □ | Describe: ________________________________________ |
| Any chronic or frequent medical problems? | □ | □ | Describe:________________________________ |

Any specialty doctors___________________________________________________________________

Current medications_____________________________________________________________________

Known allergies_________________________________________________________________________

| | Y | N |
|---|---|---|
| Feeding difficulties as infant | □ | □ |
| Concerns about weight gain | □ | □ |
| Very picky eater | □ | □ |

| | Y | N | | Comments |
|---|---|---|---|---|
| Any concerns now about your child's | □ | □ | | ________________________________ |
| -eating or nutrition? | □ | □ | | ________________________________ |
| -sleep habits | □ | □ | | ________________________________ |
| -problems with bowel movements | □ | □ | | ________________________________ |
| -frequent aches and pains | □ | □ | | ________________________________ |
| -weakness or poor coordination | □ | □ | | ________________________________ |
| -breathing problems | □ | □ | | ________________________________ |
| Has your child's hearing been tested? | □ | □ | Result: | ________________________________ |
| Has your child's vision been tested? | □ | □ | Result: | ________________________________ |

MR #:
Name:

# CHILD DEVELOPMENT QUESTIONNAIRE

**EARLY DEVELOPMENT:**
**Please note the age at which your child first did each of the following.** Put "not yet" if he/she does not do this.
Sat up without help:_____________ Crawled:_________________ Walked alone: _________________
Said first word:_________________ Put two words together ("my ball," "mommy go"): _______________
Toilet trained:___________________Tied shoes_______________ Read words:___________________
Are there things that he/she used to be able to do but doesn't or can't do anymore? □Y □N

**EARLY BEHAVIOR:**
Please note if any of the following was a problem or concern **during the first 2 years** of your child's life.

| | Not a problem | Mild or occasional | Big problem |
|---|---|---|---|
| 1. Feeding difficulties | | | |
| 2. Sleeping difficulties | | | |
| 3. Rhythmic behaviors (ie, head banging, rocking) | | | |
| 4. Hard to console or comfort | | | |
| 5. Floppy or weak | | | |
| 6. Excessive crying | | | |
| 7. Not interested in other people | | | |
| 8. Not affectionate | | | |

**PRESENT BEHAVIOR:**
**Skip this section if your child is less than 2 years old.**
Please note if any of the following are a problem or concern for your child now, more than for other children his/her age.

| | Not a problem | Mild or occasional | Big problem |
|---|---|---|---|
| 1. Sensitive, cries easily | | | |
| 2. Often seems confused | | | |
| 3. Sleeps poorly | | | |
| 4. Often sad | | | |
| 5. Often wets pants or bed | | | |
| 6. Bowel movement accidents | | | |
| 7. Eats or mouths non-food items | | | |
| 8. Refuses to obey | | | |
| 9. Very shy | | | |
| 10. Temper tantrums | | | |
| 11. Hurt people or damaged property | | | |
| 12. Anxious or nervous | | | |
| 13. Uses peculiar speech | | | |
| 14. Unusual fears | | | |
| 15. Difficulty making or keeping friends | | | |
| 16. Nervous habits or tics | | | |

MR #:
Name:

# CHILD DEVELOPMENT QUESTIONNAIRE

Additional Behavior Comments:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**FAMILY HISTORY (all ages):**
**Please indicate if any immediate family members have had:**

| Condition | Child's Father | Child's Mother | Child's Brother(s) | Child's Sister(s) |
|---|---|---|---|---|
| 1. Speech problems | □ | □ | □ | □ |
| 2. Hyperactive as a child | □ | □ | □ | □ |
| 3. Difficulty in school | □ | □ | □ | □ |
| 4. Behavior problems as a child | □ | □ | □ | □ |

**Please indicate if any family members (including grandparents, aunts, uncles, cousins, etc.) have had any of the following:**

| Condition | Y | N | Relation to child | Current age, other comments |
|---|---|---|---|---|
| 1. Mental retardation | □ | □ | ________________ | __________________________ |
| 2. Mental illness or disorder | □ | □ | ________________ | __________________________ |
| 3. Birth defects | □ | □ | ________________ | __________________________ |
| 4. Seizures/convulsions | □ | □ | ________________ | __________________________ |
| 5. Neurological disorder | □ | □ | ________________ | __________________________ |
| 6. Muscle disease | □ | □ | ________________ | __________________________ |
| 7. Genetic disorder | □ | □ | ________________ | __________________________ |
| 8. Hearing problem | □ | □ | ________________ | __________________________ |
| 9. Death in infancy | □ | □ | ________________ | __________________________ |

Details: ______________________________________________________________________
______________________________________________________________________________

**EDUCATIONAL INFORMATION:** (for children over 3)

| | Y | N |
|---|---|---|
| Is your child receiving special education services (has an IEP).......................................... | □ | □ |
| If so, please provide past evaluations and the IEP to the developmental pediatrician. | | |
| Has your child ever repeated a grade? ................................................................................ | □ | □ |
| Does the teacher have any concerns about your child's learning?...................................... | □ | □ |
| Does the teacher have any concerns about your child's behavior?.................................... | □ | □ |
| Does your child like to go to school?..................................................................................... | □ | □ |

Comments: ____________________________________________________________________
______________________________________________________________________________

**Thank you very much for taking the time to complete this questionnaire.**
Please use the space below for any additional information, or any other questions you may have about your child's development or behavior.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________