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, Dr. Mark Cohen. 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 Dr. Cohen, 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 Dr. Cohen.
**CHILD DEVELOPMENT QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>CHILD’S FULL NAME</th>
<th>KAISER PERMANENTE MRN NO.</th>
<th>CHILD’S BIRTH DATE</th>
<th>TODAY’S DATE</th>
</tr>
</thead>
</table>

**NAME OF PERSON(S) COMPLETING THIS FORM**

<table>
<thead>
<tr>
<th>RELATIONSHIP TO CHILD</th>
<th></th>
</tr>
</thead>
</table>

**WHAT DOES YOUR CHILD LIKE TO BE CALLED?**

<table>
<thead>
<tr>
<th>CHILD’S SCHOOL (OR PRESCHOOL)</th>
<th>GRADE</th>
</tr>
</thead>
</table>

**FATHER’S NAME**

<table>
<thead>
<tr>
<th>AGE</th>
<th>SCHOOL LEVEL COMPLETED</th>
<th>EMPLOYMENT</th>
<th>ETHNIC BACKGROUND (OPTIONAL)</th>
</tr>
</thead>
</table>

**MOTHER’S NAME**

<table>
<thead>
<tr>
<th>AGE</th>
<th>SCHOOL LEVEL COMPLETED</th>
<th>EMPLOYMENT</th>
<th>ETHNIC BACKGROUND (OPTIONAL)</th>
</tr>
</thead>
</table>

**WHAT LANGUAGES ARE SPOKEN AT HOME?**

| ☐ English | ☐ Spanish | ☐ Other: |

**CURRENT MARITAL STATUS OF PARENTS (CHECK ONE)**

| ☐ Married | ☐ Separated | ☐ Divorced | ☐ Living together | ☐ Other: |

**WITH WHOM DOES THE CHILD LIVE? (E.G., BOTH PARENTS, STEP-PARENT, FATHER, MOTHER, GRANDPARENT, FOSTER PARENTS, ETC.)**

**PHONE NUMBERS: HOME WORK CELL**

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**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: ☐

<table>
<thead>
<tr>
<th>Problem</th>
<th>Age noted</th>
<th>Diagnosis (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CHILD’S SIBLINGS:**

<table>
<thead>
<tr>
<th>Sibling’s full name</th>
<th>Date of birth</th>
<th>Health or developmental problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</tbody>
</table>
MOTHER’S PRENATAL HISTORY:
If the child’s mother is not completing this form, please provide as much information as possible.

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

YOUR CHILD’S BIRTH:
Include as much information as you know.

Birth weight: ___________ Apgar scores: ___________ Delivery: ☐ Vaginal ☐ C-section

Baby breathed immediately ☐ Y ☐ N
Baby cried immediately ☐ Y ☐ N
Required any treatment in delivery room ☐ Y ☐ N
Was in NICU (Intensive care) ☐ Y ☐ N
Stayed in hospital longer than mother ☐ Y ☐ N

YOUR CHILD’S HEALTH:
Feeding difficulties as infant ☐ Y ☐ N
Slow weight gain ☐ Y ☐ N
Excessive spitting up or reflux ☐ Y ☐ N
Difficulty with solid foods ☐ Y ☐ N
Very picky eater ☐ Y ☐ N
Any concerns about your child’s eating or nutrition now? ☐ Y ☐ N

Has your child’s hearing been tested? ☐ Y ☐ N
 Result: ____________________________

Has your child’s vision been tested? ☐ Y ☐ N
 Result: ____________________________

Any chronic or frequent medical problems? ☐ Y ☐ N
 Describe: ____________________________


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: _______________

Used a spoon: _______________ Drank from regular cup: _______________

Said first word: _______________ Put two words together (“my ball,” “mommy go”): _______________

Recited alphabet: _______________ Counted to ten: _______________ 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.

1. Feeding difficulties
2. Sleeping difficulties
3. Rhythmic behaviors (i.e., head banging)
4. Hard to console or comfort
5. Floppy
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.

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Child's Father</th>
<th>Child's Mother</th>
<th>Child's Brother(s)</th>
<th>Child's Sister(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Speech problems</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Hyperactive as a child</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Difficulty in school</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Behavior problems as a child</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
<th>Relation to child</th>
<th>Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental retardation</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
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<tr>
<td>2. Mental illness or disorder</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
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<tr>
<td>3. Birth defects</td>
<td>☐</td>
<td>☐</td>
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<td></td>
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<tr>
<td>4. Seizures/convulsions</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>5. Neurological disorder</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>6. Muscle disease</td>
<td>☐</td>
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<td>7. Genetic disorder</td>
<td>☐</td>
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<tr>
<td>8. Hearing problem</td>
<td>☐</td>
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<tr>
<td>9. Death in infancy</td>
<td>☐</td>
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</tr>
</tbody>
</table>

Details: ________________________________________________________________

EDUCATIONAL INFORMATION:
Has your child ever repeated a grade? ......................................................... ☐ Y ☐ N
Is your child receiving special education services? ............................................. ☐ Y ☐ N
Have you ever been told that your child was having problems in school? ..................... ☐ Y ☐ N

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.