In order to submit this form, you should open it with Adobe Acrobat Reader.

Pediatric Pre-Evaluation Questionnaire

Please provide the name and relationship of the individual completing the form.

Reporting Individual's Name *

First Name Last Name

Relationship to the child *

Phone Number *

Area Code Phone Number

INSTRUCTIONS FOR COMPLETING

Please answer the following questions about your child's health and history. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to best use your assessment time with her/him by enabling a more detailed focus.

Demographics

Child's Name *

First Name Middle Name Last Name

Child's Date of Birth *

Month Day Year

Child's Sex *

Child's Handedness (if known) *

Child's Ethnicity *

Child's Pediatrician *

Doctor's Name

Pediatrician's Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Pediatrician's Phone Number *

Area Code Phone Number

Pediatrician's Fax Number

Area Code Phone Number

May we contact your child's doctor? *

○ Yes ○ No

Referral Information

Who referred you for this evaluation? *

If referred by a specific physician, mental health care provider, or other specialist, please provide his/her name, specialty, and contact information below:

Name of referral *

Specialty

Address of referral

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Referral's Phone Number *

Area Code Phone Number

Referral's Fax Number

Area Code Phone Number

May we contact the provider that referred you? *

Yes No

Presenting Problem

Please describe what concerns you have with your child's behaviors or development. Also describe how long your child has been experiencing these problems and a brief description of the course *

Did these changes have an abrupt or gradual onset? *

◯ Abrupt ◯ Gradual

Please describe any social/family/emotional stress and/or environmental changes that occurred around the time of onset?

Prenatal Development

What was the length of pregnancy with this child?

Length in weeks

Did birth mother experience any of the following complications during pregnancy?

- ☐ Difficulty with conception
- ☐ Excessive vomiting
- ☐ Vaginal bleeding
- ☐ Toxemia
- ☐ German Measles
- ☐ Flu
- ☐ Physical injures
- ☐ Abnormal weight gain
- ☐ Excessive swelling
- ☐ Anemia
- ☐ Measles
- ☐ Emotional problems
- ☐ High blood pressure
- ☐ _____

Was birth mother hospitalized during pregnancy?

- ○ Yes*
- ○ No

***If yes, please explain why and at what month of the pregnancy was she was hospitalized.**

Did birth mother undergo x-rays or other imaging procedures during pregnancy?

- ○ Yes*
- ○ No

***If yes, please explain the purpose of the imaging and at what month of the pregnancy this occurred.**

Did birth mother take any medications during pregnancy?

- ○ Yes*
- ○ No

***If yes, please explain what medications and dosages were taken during pregnancy.**

Did mother and/or father use any alcohol, tobacco, and/or other drugs while trying to conceive?

◯ Yes* ◯ No

***If yes, please explain what substances were used and the frequency of use while trying to conceive.**

Did birth mother use any alcohol, tobacco, and/or other drugs during pregnancy?

◯ Yes* ◯ No

***If yes, please explain what substances were used and the frequency of use during pregnancy.**

Any other comments/problems related to prenatal devlopment.

Labor and Birth

Biological Mother's age at birth of child

Years

Biological Father's age at birth of child

Years

Was this child born in a hospital?

Yes* No

***If yes, what hospital?**

What was the length of labor in hours?

Were there any complication with mother or child during labor and/or at birth?

Yes* No

***If yes, please explain what complications occurred during labor and/or at birth.**

Please check any relevant birth details.

- ☐ Vaginal delivery
- ☐ Forceps use
- ☐ Induced labor
- ☐ Jaundiced*
- ☐ Supplemental oxygen
- ☐ NICU admission
- ☐ Cesarean section
- ☐ Breech birth
- ☐ Incubator needed
- ☐ Breathing problems right after birth*
- ☐ Birth defects
- ☐

***If jaundiced, were bilirubin lights used and for how long?**

***Please described more about the child's breathing problems after birth?**

What was the child's birth weight?

What was the child's Apgar score?

Do you think the child's current difficulties might be related to pregnancy, labor, or delivery?

- ◯ Yes*
- ◯ No

***If yes, explain your concerns about the relationship to pregnancy, labor, or delivery and the child's difficulties.**

Any other comments/problems related to labor and birth history.

Infancy and Early Development

At what age did the child first do the following (in months)?

	In months
Turned over	
Sat alone	
Crawled	
Stood alone	
Walked alone	
Fed self with spoon	
Scribbled	
Understood first words	
Spoke first words	
Spoke in sentences	
Toilet train (days)	
Toilet train (nights)	

Has the child ever received speech/language therapy?

◯ Yes* ◯ No

***If yes, please explain when speech/language therapy began, where the child attended therapy, and is the child still participating in therapy.**

Has the child ever received occupational therapy?

◯ Yes* ◯ No

***If yes, please explain when occupational therapy began, where the child attended therapy, and is the child still participating in therapy.**

Has the child ever received physical therapy?

◯ Yes* ◯ No

***If yes, please explain when physical therapy began, where the child attended therapy, and is the child still participating in therapy.**

Did bed-wetting and/or bed soiling occur after training?

◯ Yes* ◯ No

***If yes, please explain what age bed-wetting and/or soiling occurred and are there concerns with behaviors?**

Please rate the child on the following behaviors during infancy and early childhood.

	Not at all	A little	Somewhat	Mostly	All the time
Colic and irritable	○	○	○	○	○
Feeding problems	○	○	○	○	○
Sleeping problems	○	○	○	○	○
Restless	○	○	○	○	○
Overactive	○	○	○	○	○
Does not enjoy cuddling	○	○	○	○	○
Tantrums and/or head banging	○	○	○	○	○
Accident prone and/or daredevil	○	○	○	○	○
Uncoordinated	○	○	○	○	○
Avoids eye contact	○	○	○	○	○
Dislikes contact with people	○	○	○	○	○

Did any event, health condition, separation, etc. disturb infant/parent bonding or the developing toddler/parent relationship?

○ Yes* ○ No

***If yes, please explain what issues may have contributed to difficulties with the child/parent relationship.**

Any other comments/problems related to infancy and early developmental history.

Behavioral and Emotional History

Please check all behaviors that that the child exhibits currently or has had in the past:

	Yes	No	What age and treatment
Sucks thumb	○	○	
Grinds teeth	○	○	
Bites nails	○	○	
Picks skin	○	○	
Tics/twitches	○	○	
Rocks back and forth	○	○	
Unusual body movements	○	○	
Bangs head	○	○	
Physically hits self	○	○	
Physically hits others	○	○	
Lies	○	○	
Steals or hides other's things	○	○	
Hoards	○	○	
Chronically overeating to the point of getting sick	○	○	
Purposefully vomiting	○	○	
Restricting food intake	○	○	
Cuts self	○	○	
Threaten to kill his or herself	○	○	

Has the child ever has psychological counseling or therapy?

○ Yes* ○ No

***If yes, please list the provider's name, phone, and date of services below.**

	Name of provider	Phone number	From (date)	To (date)
1				
2				
3				
4				

Has the child ever had a prior psychiatric or neuropsychological evaluation?

◯ Yes* ◯ No

***If yes, please describe dates and details from the prior evaluations.**

Has the child ever witnessed violence inside or outside of the home?

◯ Yes* ◯ No

***If yes, please provide details of what the child witnessed below.**

Please described any major family or parental stress that may have impacted the child in the past or that may impact him or her currently.

Are there any particular traumatic or troubling events which have happened in this child's life which we should know in order to better understand him/her? (Please give details, including incidents you feel were traumatizing for this particular child, though the event might not have been for another child.)

Has the child ever been psychiatrically hospitalized?

○ Yes* ○ No

***If yes, please describe dates and what hospital the child was psychiatrically hospitalized.**

What time does the child go to bed?

What time does the child wake up?

	Yes	No	How long?
Does your child nap during the day?	○	○	

	Yes	No	Please describe
Does the child have a consistent bedtime routine?	○	○	
Are you concerned that the child does not get enough sleep and/or has poor sleep quality?	○	○	

Please check any traits/characteristics below which apply to the child now.

- ☐ Happy
- ☐ Moody
- ☐ Quiet
- ☐ Independent
- ☐ Sensitive
- ☐ Fearful
- ☐ Tantrums
- ☐ Requires parental attention
- ☐ Even tempered
- ☐ Impulsive
- ☐ Lack of self-control
- ☐ Volatile
- ☐ Thoughtful
- ☐ Difficulty calming down
- ☐ Withdrawn
- ☐ Sad
- ☐ Friendly
- ☐ Overactive
- ☐ Dependent
- ☐ Affectionate
- ☐ Overreacts when faced with problems
- ☐ Lethargic
- ☐ Too responsible
- ☐ Short attention span
- ☐ Angry
- ☐ Explosive
- ☐ Withholding of affection
- ☐ Dreamer
- ☐ Cooperative

Any other comments/problems related to behavioral and emotional history.

Family/Social History

Biological Mother's Name

First Name Last Name

Biological Father's Name

First Name Last Name

The child is living with: *

- ◯ Both parents
- ◯ Mother
- ◯ Father
- ◯ Legal guardian
- ◯ Foster care
- ◯

Status of parent's marriage: *

- ◯ Married
- ◯ Never married
- ◯ Separated
- ◯ Divorce
- ◯ Widowed
- ◯

If parents are divorced, please indicate whether there are stepparents.

☐ Stepmother ☐ Stepfather

Is the child adopted?

◯ Yes ◯ No

Are there parental custody arrangements for this child?

◯ Yes* ◯ No

***If yes, please briefly describe these custody arrangements.**

Who has legal custody of the child?

Please complete the following information regarding biological parents in the appropriate column.

	Mother	Father
Age		
Highest level of education complete		
Degrees/diplomas		
Current occupation.		
Describe any special education or tutoring received.		
Describe grades repeated or subject areas that were difficult.		
Any diagnosed learning difficulties? If so, in what subjects?		
Any psychological or psychiatric problems for which treatment was received?		
Any diagnosis of attention deficit disorder (with or without hyperactivity)?		

List the name, age, relationship, and any medical, mental health, or development diagnoses of all the individuals the child lives with currently.

	Name	Age	Relationship	Any diagnoses?
1				
2				
3				
4				
5				
6				
7				
8				

Do any biological extended family members suffer from any of the following conditions?

	Maternal (mother's side)	Paternal (father's side)	Relationship
Attention deficit disorder	☐	☐	
Learning difficulties	☐	☐	
Behavioral problems	☐	☐	
Seizures/epilepsy	☐	☐	
Migraines	☐	☐	
Alcoholism/drug abuse	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Bipolar disorder	☐	☐	
Schizophrenia	☐	☐	
Autism	☐	☐	
Other developmental disability	☐	☐	
Congenital abnormalities	☐	☐	
Other neurological conditions	☐	☐	

Please provide any additional information about the child's extended family that might help us understand the child's needs.

Which of the following best describes the way the child is related to by other children?

- ◯ The child is very popular with his/her peers.
- ◯ The child is nether popular or unpopular with his/her peers.
- ◯ The child is unpopular with his/her peers.

Which best described the role of the child takes with peer interactions?

- ◯ The child likes to be the leader most of the time.
- ◯ The child prefers to follow other kids.
- ◯ The child can flexibly take the role of either the leader or the follower depending on the situation.

Please rate the child's ability to relate to other children.

	Yes	No	Please explain
Does the child have difficulty relating to other children?	○	○	
Does the child physically fight with other children?	○	○	
Does the child argue with other children?	○	○	
Does the child prefer playing with younger children?	○	○	
Does the child prefer playing with older children or adults?	○	○	
Does the child have difficulty making friends?	○	○	
Does the child have difficulty maintaining friendships?	○	○	
Does the child have a best friend?	○	○	
Is the child invited to other children's houses for play dates?	○	○	
Is the child invited to birthday parties as often as you think he/she should be?	○	○	
Are there children in your neighborhood with whom the child can play?	○	○	
Does the child prefer to play alone?	○	○	
Does the child have difficulty with the nonverbal rules of social interaction (e.g., turn taking, how close to stand to others).	○	○	

Is the child enrolled in any extracurricular activies or hobbies (e.g., team or individual sports, music lessons, karate, boy/girl scouts, etc...)? Please list:

Any other comments/problems related to social history.

Educational History

	Name of school	Grade	Teacher's name
The child's current school.			

Please identify all prior preschools/day cares and schools that the child has attended.

	Names of preschool/day care/school	Grade	From (date)	To (date)	# day a week	# hours a day
1						
2						
3						
4						
5						

Is English the child's primary language?

○ Yes ○ No

Specify the child's primary language and/or other languages he/she speaks.

Are there school subjects that are more difficult than others for the child?

◯ Yes* ◯ No

***If yes, please specify and describe which subjects and difficulties the child is experiencing.**

Has the child ever failed any classes or been held back in school?

◯ Yes* ◯ No

***If yes, please describe what classes the child has failed or when the child was held back.**

Does the child have any behavioral issues at school?

◯ Yes* ◯ No

***If yes, please describe behavioral issues the child has at school.**

Described what you hear from the child's current teachers about the child's experience in school.

Does the child currently have an Individualized Education Program (IEP) or 504 plan?

◯ Yes* ◯ No

***If yes, please briefly describe educational services that the child is currently receiving. Please bring any copies of IEP and 504 plans to the initial appointment.**

Any other comments/problems related to educational history.

Medical History

Please check all medical conditions that the child has or have had in the past:

General Conditions

	Yes	No	What age and treatment
Measles	○	○	
German measles	○	○	
Mumps	○	○	
Chicken pox	○	○	
Tuberculosis	○	○	
Rheumatic fever	○	○	
Diphtheria	○	○	
Meningitis	○	○	
Encephalitis	○	○	
Whooping cough	○	○	
Scarlet fever	○	○	
Sustained high fever	○	○	
Any fever above 104 degrees	○	○	
Anemia	○	○	
Allergies to food	○	○	
Environment allergies	○	○	
Uses hearing aid	○	○	
Wears glasses/contact lenses	○	○	

Respiratory Conditions

	Yes	No	What age and treatment
Frequent colds	○	○	
Chronic cough	○	○	
Asthma	○	○	
Hay fever	○	○	
Sinus condition	○	○	
Chronic sinus infection	○	○	
Sleep apnea	○	○	
Other respiratory conditions	○	○	

Cardiovascular Conditions

	Yes	No	What age and treatment
Shortness of breath with exertion	○	○	
Dizziness with exertion	○	○	
Heart condition	○	○	
Heart condition	○	○	
Heart murmur	○	○	
Blood clots	○	○	
Other cardiovascular conditions	○	○	

Gastrointestinal Conditions

	Yes	No	What age and treatment
Excessive vomiting	○	○	
Frequent diarrhea	○	○	
Constipation	○	○	
Stomach pain	○	○	
Heartburn/acid reflux	○	○	
Other gastrointestinal conditions	○	○	

Musculoskeletal Conditions

	Yes	No	What age and treatment
Muscle pain	○	○	
Clumsy walk	○	○	
Poor posture	○	○	
Scoliosis	○	○	
Broken bones	○	○	
Other musculoskeletal conditions	○	○	

Skin Conditions

	Yes	No	What age and treatment
Frequent rashes	○	○	
Bruises easily	○	○	
Sores	○	○	
Acne	○	○	
Eczema	○	○	
Other skin conditions	○	○	

Neurological Conditions

	Yes	No	What age and treatment
Seizures	○	○	
Brain injury/concussion	○	○	
Stroke	○	○	
Brain tumor	○	○	
Abrupt mental status change	○	○	
Spinal cord injury	○	○	
Other neurological condition	○	○	

List any surgeries (operations) the child has undergone and dates associated with each procedure.

List any hospitalization the child has had and dates associated with each admission.

List any neuroimaging (e.g., head CT, MRI of the brain) the child has had with dates and ordering physician.

Does the child have any drug allergies? *

- ◯ Yes*
- ◯ No

***If yes, please state which drugs you are allergic to and the reaction you receive from the drug.**

List all medicines that the child uses. (prescription, non-prescription, and natural products)

	Name of medication (e.g., Tylenol)	Strength (Dose) (e.g., 500 mg)	How often per day (e.g., 1 pill 3 times a day)
1			
2			
3			
4			
5			

Any other comments/problems related to medical history.

Emergency Contact

Name of Emergency Contact *

First Name Last Name

Relationship *

Emergency Contact Phone Number *

Area Code Phone Number