DIVISION OF DEVELOPMENTAL & BEHAVIORAL PEDIATRICS
BOSTON MEDICAL CENTER

617-414-4841 ext. 1 then ext. 2

PARENT QUESTIONNAIRE:

NAME OF CHILD _____**DOB:** _____

Name of Parent/Guardian #1 _____

Name of Parent/Guardian # 2 _____

Best Number to reach you: _____

Child's physician: _____

Whose idea was it for this evaluation?

_____

_____

Reason for Referral:

_____

_____

_____

What would you like to gain from this evaluation?

_____

_____

Has your child ever been evaluated previously for developmental, behavioral, or learning problems? ❑ No ❑ Yes

If so, when, who provided the evaluation, what type of evaluation did the child have, and what were you told about your child regarding the results of any evaluations?

_____

_____

_____

_____

_____

_____

_____

Prenatal information:
Birth History of your Child: Please circle: Yes or No to those that apply

Birth History	Apgar 1 min	Apgar 5 min	Hospital
Vaginal delivery Yes/No	C-section delivery Yes/No	Forceps? Yes/No	Vacuum? Yes/No
Labor hours?	Breathing problems? Yes/No	Respirator? Yes/No	Intensive Care? Yes/No
Jaundice? Yes/No	Phototherapy? Yes/No	Infection? Yes/No	Needed Oxygen? Yes/No
Discharged home with mother without prolonged stay? Yes/No	Days in Hospital	Longer hospital stay for baby? Yes/No	Longer hospital stay for mother? Yes/No

Age of mother When pregnant with this child	Number of Pregnancies	Birthweight	How many weeks was baby born?

Please mark any complications of pregnancy?

Bleeding		High blood pressure		Preterm Labor
Infection		High blood sugar/diabetes		Abnormal Ultrasound
Injury		Anemia		Other Problem

Any Medications or drugs during pregnancy?

Vitamins	Iron	Cigarettes? # Per day
Non-prescription medications? Cocaine? Marijuana? Other?	Alcohol? Times per week Beer_____ Wine_____ Other_____	Prescription medications 1. 2. 3.

Please indicate the approximate age at which your child learned to

Walk alone: _____Say Mama or Dada _____Speak Clearly_____
Eat Table food_____ Be toilet trained_____ Dress without help _____
Ride a bike without training wheels _____ Tie shoes _____
Learn the alphabet: _____ Name colors: _____

Has your child ever lost skills? Yes/No
If yes please explain: _____

Please indicate if your child has any of the following medical conditions:

	check	Age/Describe
Infant feeding problems/difficulty gaining weight		
Infant colic/excessive crying first 3 months		
Frequent ear infections		
Asthma		
Heart problems		
Digestive Problems		
Anemia		
Lead poisoning		
Stiches/broken bones		
Head injury concussion		
Passing out/fainting		
Seizure With fever? Without fever?		
Headaches Migraines?		
Stomachaches		
Difficulty falling asleep? Staying asleep? Loud snoring?		
Difficulty staying in own bed		
Overweight		
Underweight		

Too short		
Vision problems		
Hearing problems		
Soiling in underwear or constipation		
Hospitalizations:		
Operations:		

Current Medications:

Name	Dose	Reason given	Date started	Date stopped
1.				
2.				
3.				

Allergies: _____

Behavioral History:

For each Item select best answer for you child:

	Never	Sometimes	Often	Explain
Obsessive interest in narrow or atypical topic or event (e.g. fantasy, logo,tv program)				
Insists on sticking to routine				
Lacks interest in toys or uses toys in an unusual manner				
Sensitive to texture, lights, sounds, tastes				
Repeats acts or words over and over				
Lacks interests in peers				
Poor eye contact				
Unusual fears not typical for age group				
Ritualistic behaviors(ex. lining up toys)				
Speaks in an unusual tone or volume				
Repetitive movements or body postures				

Educational History:

Past School History

Grade	School/City	Learning Problems,Struggling Academically	Poor attention, off task, not finishing work. Etc.	Behavioral Problems, disrupting, out of seat, talking out, Etc.	On IEP?
Preschool					
Kindergarten					
1st grade					
2nd grade					
3rd grade					
4th grade					
5th grade					
6th grade					
7th grade					
8th grade					
9th-10th grade					
11th-12th grade					

Current School: Address: Phone: Fax:	Grade Level
Enrolled in Early Intervention services? (please bring IFSP evaluation results if available)	Yes/No
Does your child currently have an IEP (Individualized Education Program)? (please bring IEP with you if available)	Yes/No

Current problems with learning:

Reading		Writing		Comprehension	
Spelling		Math		Speech/Language	

Current behavioral problems in the classroom:

Inattention		Impulsivity		Aggression	
Distractibility		Disrespect		Talking out	
Hyperactivity		Oppositionality		Bothering others	

Does your child have an IEP?
Has s/he been suspended or expelled from school (or bus, or after-school programs)?
Has s/he repeated a grade?
Has s/he been in an advanced academic program or skipped a grade?
Extracurricular activities (sports, music, clubs, drama)?
How does s/he get along with teachers?
How does s/he get along with other students?
Have his/her grades fallen off recently?

Family History

Name of parent 1	Name of parent 2
Age: Occupation:	Age: Occupation:
Highest Grade completed:	Highest Grade completed:
Medical Problems:	Medical Problems:
Problems of Learning?	Problems of Learning?
Problems with Focus/Attention?	Problems with Focus/Attention?

Step Parents?

Name	Age	Occupation
Name	Age	Occupation

Siblings

Name	Age	Grade	Learning or Medical Problems

Any of the following Medical or Developmental problems in the extended family?

Problem	Mother's side	Father's side	Explain/relationship to child
Birth defects			
Cognitive delay/mental retardation/intellectual disability			
Vision or hearing problems			
Learning problems			
Attentional problems			
Speech or language delay			
Autism spectrum disorder			
Tics/Tourette's syndrome			
Depression			
Obsessive compulsive disorder			
Physician diagnosed bipolar or manic depressive disorder			
Seizure disorder/Epilepsy			
Alcohol dependency			
Drug Dependency			

Social history:

Child lives with:_____

Language spoken in the home: _____
Has child ever lives in foster home or alternative care?_____

Any additional comments you would like to share_____
_____
_____

Thank you!