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Children's Hospital
Greenville Health System

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DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
PARENT QUESTIONNAIRE FOR AGES 6 AND OLDER

Thank you for providing this information, which will help us better plan for your child's evaluation. Please contact our Social Workers at 454-5115 if you have any questions or would like help in completing the questionnaire.

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Date:_____ Form completed by:_____ Relationship to child: _____

Father's Name:_____ Mother's Name: _____

Legal guardian of child: _____ Relationship: _____
Circle One: Adopted Natural Foster

What is the primary language spoken at home? English _____Spanish _____ Other _____

What concerns about your child would you like us to address? _____

_____

_____

How old was your child when you first became concerned? _____

How has the problem changed over time? _____

_____

_____

Has your child received any of the following services or therapies? **(Please circle all that apply)**

CRS BabyNet DDSN DSS Early Interventionist Speech Therapy Occupational Therapy

Physical therapy Developmental Pediatrician Psychiatrist Other Mental Health provider Psychologist

If yes to above, please indicate which provider or agency provided services & when:_____

_____

_____

How did your child respond to these services?_____

_____

_____

What do you like about your child? _____

_____

How does your child get along with other family members and other children? _____

_____

What are your child's interests or favorite play activities? _____

_____

Child's Name _____ Date of Birth: _____

PREGNANCY, BIRTH AND HEALTH HISTORY: During pregnancy with the child, did the mother (Check if yes):

	Yes	Describe
Have any infection		
Have toxemia or high blood pressure		
Have sugar in the urine/diabetes		
Have unusual emotional strain		
Drink alcoholic beverages (if yes, how much)		
Smoke (if yes, how much)		
Use medications other than prenatal vitamins		
Use illegal/street drugs (if yes, list drugs)		
Bleeding or spotting		
Preterm labor		
Excess weight gain (more than 30 pounds)		
Poor weight gain (less than 10 pounds)		
Excessive nausea and vomiting		
Any contact with possible toxic products		
Have unusual physical strain or injury		
Have to be hospitalized (if yes, why)		

How many times was the mother pregnant before this child? _____

Was this pregnancy planned? Yes_____ No____

Did the mother have difficulty getting pregnant? Yes____ No____

When was prenatal care begun?_____

Mother's age when child born: _____ Father's age when child born:_____

Any concerns for sadness or depression during or immediately after the pregnancy?_____

Any other problems or concerns during the pregnancy? _____

Name and location of hospital where child was born:_____

How long was the pregnancy? Full Term _____ Other (indicate how long)_____

Birth weight: _____lbs _____oz Apgar scores, if known:_____

Type of Labor: Spontaneous_____ Induced _____ Duration (hrs)_____

Type of Delivery: Vaginal_____ Breech_____ Scheduled Caesarean_____

Emergency Caesarean_____ Forceps/vacuum_____

Complications at delivery: Cord around of the neck_____ Infant injured during delivery_____

Trouble breathing _____ Swallowed fluid/meconium_____

How long did your baby stay in the hospital after birth?_____

Was baby in the NICU/Special Care Nursery? Yes No If yes, how long?_____

Check any of the following problems occurring while your child was in the nursery:

Breathing problems		Seizures		Birth Defect		Cried excessively	
Jaundice (yellow)		Infection		Feeding Problems		Other_____	

Child's Name _____ Date of Birth: _____

As an Infant: During the first year, were there problems in any of the following areas? If yes, please describe.

Feeding: _____

Sleep: _____

Colic: _____

Difficulty comforting: _____

Did not enjoy cuddling: _____

Overactivity: _____

Excessive irritability or tantrums (such as with diaper changes): _____

Overly floppy or stiff: _____

Developmental concerns: _____

Health History: Has the child had any of the following?	Yes	No	Age
1. Convulsions, seizures, fainting spells	_____	_____	_____
2. Vision or eye problems	_____	_____	_____
3. Recurrent ear infections	_____	_____	_____
4. Hearing Problems	_____	_____	_____
5. Any serious accidents or injuries?	_____	_____	_____
If yes, describe: _____			
6. Has your child had any surgeries?	_____	_____	_____
If yes, what & when: _____			
7. Has your child been hospitalized overnight?	_____	_____	_____
If yes, why & when? _____			
8. Does your child have any medical diagnoses?	_____	_____	_____
If yes, describe: _____			
Names of other doctors your child sees: _____			
9. Any history of lead poisoning or other poisoning?	_____	_____	
10. Has child had a routine check-up within the past 12 months?	_____	_____	
11. Has your child had a serious reaction to an immunization?	_____	_____	_____
If yes, describe: _____			
12. Does your child have any allergies to Medications?	_____	_____	
If yes, what medication & what is reaction? _____			
_____			

Medications that your child is on now (please list any additional on a separate page):

Names of Medication	Dose	Side effects noted	Response to medication

Medications previously taken regularly by your child (please list any additional on a separate page):

Names of Medication	Dose	Side effects noted	Response to medication

Child's Name _____ Date of Birth: _____

Review of Systems: Please check if your child is having or has had any of the following complaints.

Neurological		**Gastrointestinal**		**Metabolic**	
Headaches		Decreased appetite		Fever	
Staring spells		Increased appetite		Chills	
Seizures		Nausea		Decreased energy	
Weakness		Vomiting		Excessive weight gain	
Dizziness		Diarrhea		Excessive weight loss	
Abnormal movements		Constipation			
Fainting spells		Soiling underwear		**Musculoskeletal**	
Tics/twitches		Stomachaches		Joint pain	
		Choking		Joint swelling	
Cardiorespiratory				Muscle aches	
Chest pain		**GU**		Muscle weakness	
Racing heart		Frequent urination			
Irregular rate		Painful urination		**Sleep problems**	
Wheezing		Daytime accidents		Trouble falling asleep	
Coughing		Bedwetting		Bedtime refusal	
Trouble breathing		Urinary infections		Nightmares	
				Night terrors	
Skin		**Psychiatric**		Sleep walks	
Rashes		Anxiety		Sleeps with parents	
Birthmarks		Hallucinations		Wakes up nightly	
		Depression			
Immunologic		Obsessions		**Dental problems**	
Repeated infections		Hyperactivity		Cavities	
		Hurts or bites self		Dental surgery	
Hematologic		Seems in own world			
Easy bruising					
Nose bleeds					

DEVELOPMENTAL HISTORY

How old do you think your child acts? _____

Do you or have you had any concerns about the following. If yes, please describe:

Your child's speech: _____

Your child's coordination (ex. walking, running, sports): _____

Your child's fine motor skills (ex. snapping, using utensils): _____

Your child's writing or drawing: _____

Your child's self help skills (toileting, bathing, dressing, etc): _____

Your child's ability to interact with others: _____

FAMILY HISTORY

Mother's health: _____

School grade completed: _____ Present Occupation: _____

Father's health: _____

School grade completed: _____ Present Occupation: _____

Are any siblings deceased? _____

Are the child's parents related in any way except by marriage? Yes___ No___

Child's Name _____ Date of Birth: _____

Please complete below for brothers and sisters of child (include ½ brothers and sisters):

Name	Age	Relationship	Development/Learning (normal/advanced/delayed)	Any diagnoses

Please check if any of the child's relatives (such as cousins, aunts, uncles, grandparents) have had any of the following conditions:

CONDITION	Mother	Mother's Mother	Mother's Father	Mother's siblings	Cousins	Father	Father's Mother	Father's Father	Father's siblings	Cousins
ADHD										
Learning problems										
Dyslexia										
Anxiety										
Depression										
Nerve/Emotional problems										
Schizophrenia										
Autistic disorder										
Diabetes										
Drug/alcohol abuse										
Speech problems										
Heart disease										
Cancer										
Mental retardation										
Genetic disorders										
Seizures										
Neurological /Tic disorders										
Hearing loss										
Kidney disease										

SCHOOL HISTORY

Where does your child attend school?_____Current Grade:_____

How long has your child been at this school?_____

Has your child repeated a grade?_____If yes, which one?_____

Has your child ever been suspended or expelled from school? Yes_____No____If yes, why? _____

_____

How does your child feel about school?_____

_____

How long does your child spend on homework?_____

How long do you think your child should spend on homework?_____

Child's Name _____ Date of Birth: _____

Do you think your child could complete homework in less time? Yes____No____If no, why?_____

_____

What were your child's grades on the most recent report card? Language Arts_____Math_____

Science_____ Spelling _____Social Studies/History_____Conduct/Citizenship_____

Has your child ever received Special Education services or resource? Yes_____ No____

Which grade(s)?_____

Does your child currently have an Individualized Education Plan (IEP) Yes_____ No____

Is your child in a special class? Yes ____No ____ If yes, please describe:_____

Check any of the following concerns your child's teachers have reported to you.

Failing grades		Is inattentive		Has trouble learning	
Fails to complete homework		Can't get organized		Talks too much	
Fails to turn in homework		Loses items		Trouble with classmates	
Fails to complete class work		Has trouble taking notes		Has trouble writing	
Can't stay on task		Doesn't listen		Disturbs the class	

Where does your child attend daycare or go after school?_____

How long has your child been at this daycare/program?_____

Have you ever been asked to remove your child from a program?_____

SOCIAL HISTORY

Who lives in the home?_____

During the past 12 months have there been any changes in family circumstances?

			Describe
Has there been a loss or change in job status?	Yes	No	_____
Has there been an addition or loss of family members?	Yes	No	_____
Has anyone close to your child died recently?	Yes	No	_____
Has anyone had a major illness?	Yes	No	_____
Has your child changed schools or daycares?	Yes	No	_____
Have you moved?	Yes	No	_____

Other changes or concerns that you think may be affecting your child, if any:_____

_____

_____

_____

What are your thoughts on what may have caused your child's problems? _____

_____

If you have any additional comments, please attach extra pages if necessary.

Child's Name _____ Date of Birth: _____

Pediatric Symptom Checklist (Jellinek, et al)

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor/doctor finds nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			