DEVELOPMENTAL PEDIATRICS
HEALTH & WELLNESS PC
DR ASMA J SADIQ, MD FAAP

Parent Questionnaire

Date: _____ Child's Name: _____ DOB: _____

WHO REFERRED YOU? _____

Child Study Team: _____

Case Manager: _____

Pediatrician: _____ Phone: _____

Address: _____ email: _____

Patient Name: _____

Parent Address: _____

Parent Cell Phone: _____ Home Phone: _____

Primary Concerns

What are your primary concerns regarding your child at this time? _____

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When did the concerns start?

How have they been addressed?

Social concerns/challenges:

- ☐ Poor eye contact
- ☐ Does not respond to name
- ☐ Limited facial expressions
- ☐ Guarded
- ☐ Appears to be deaf
- ☐ Poor awareness of others
- ☐ Peer interaction
- ☐ Prefers to play alone
- ☐ Social skill regression
- ☐ NO CONCERNS

Language:

- ☐ language regression
- ☐ No babbling
- ☐ Lack of gestures
- ☐ No pointing
- ☐ No single words
- ☐ No 2-word phrases
- ☐ No sentences
- ☐ Echoes
- ☐ Speaks only about interest topics
- ☐ Does not respond to questions
- ☐ Multiple grammatical errors
- ☐ Difficulty following commands
- ☐ Jargons
- ☐ Sings
- ☐ Articulation difficulties
- ☐ Hyper verbal
- ☐ Unusual volume/tone
- ☐ Speaks "adult-like"
- ☐ Hyperlexia
- ☐ Tangential/idiosyncratic language
- ☐ Needs cues and prompts
- ☐ NO CONCERNS

Repetitive/Restricted Behavior:

- ☐ Hand flapping
- ☐ Toe walking
- ☐ Rocking
- ☐ Attached to one particular toy
- ☐ Flicks fingers
- ☐ Lines up toys
- ☐ Opens/closes doors
- ☐ Turns lights on/off
- ☐ Peers at objects
- ☐ Rituals
- ☐ Spins in circles
- ☐ Spins wheels
- ☐ NO CONCERNS

Behavioral problems:

- ☐ Inattentive
- ☐ Oppositional / Attention-seeking oppositional
- ☐ Fidgety
- ☐ Distracted
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Tantrums
- ☐ Aggression
- ☐ Self-injurious behavior
- ☐ Difficulty with transitions
- ☐ Overwhelmed by crowds
- ☐ Anxiety
- ☐ Inappropriate attachment to objects
- ☐ Needs routine
- ☐ Over-focus
- ☐ NO CONCERNS

Sensory:

- ☐ Sensory seeking
- ☐ Tactile sensitivity
- ☐ Touches other people's faces
- ☐ Touches clothes a lot
- ☐ Sensitive to sound / covers ears
- ☐ Mouths objects
- ☐ Sniffs objects
- ☐ NO CONCERNS

Has your child been previously evaluated? _____

Name of evaluator: _____

Diagnosis given: _____

Early Intervention (date): _____

Child Study Team evaluations (date): _____

IEP (date, please provide if possible): _____

What are your expectations from this evaluation? _____

Child's Medical History

Mother's age at pregnancy: _____ Father's age at pregnancy: _____

# of pregnancies: _____ ☐ Full term ☐ Premature: _____ weeks

Miscarriages or still births prior to or following child's birth? ☐ No ☐ Yes: _____

Conception: ☐ natural ☐ IVF ☐ egg donor

Birth: ☐ spontaneous vaginal ☐ c-section ☐ induced vaginal ☐ vacuum

Twins/multiple births: ☐ identical ☐ fraternal

Pregnancy Complications:

Maternal illness prior to pregnancy? ☐ No ☐ Yes _____

Bleeding? ☐ No ☐ Yes _____

Hypertension? ☐ No ☐ Yes _____

Diabetes? ☐ No ☐ Yes _____

Infection? ☐ No ☐ Yes _____

Medication? ☐ No ☐ Yes _____

Smoking or substance use during pregnancy? ☐ No ☐ Yes _____

Hospital of birth: _____ Birth weight: _____

☐ Breast fed (how long: _____) ☐ Bottle fed (how long: _____)

Emotional problems during pregnancy:

Prenatal/Perinatal complications:

Neonatal complications:

NICU stay: ☐ No ☐Yes (how long:)

Infancy

Temperament: ☐ easy ☐ difficult to soothe ☐ irritable ☐ colicky

Eating habits/feeding difficulties:

Sleep difficulties:

Review of Systems / Body Areas

Ongoing medical problems:

Medications:

Allergies (food, medication, seasonal):

Surgeries:

Accidents/Trauma:

Date of most recent physical examination:

Immunization status:

History of hospitalizations and/or significant injuries/trauma:

Exposure to domestic violence, sexual abuse, or physical abuse:

Specialists involved in care:

Name: Type of specialist:

Developmental Milestones

Motor	Age Achieved	Language	Age Achieved	Daily Living	Age Achieved
Rolled over		Coo		Feed self	
Sat without support		Babble		Cup	
Crawling		Specific Mama/Papa		Toilet trained	
Stood independently		Words		Dress self	
Cruised		Phrases		Buttons	
Crawl		Sentences		Zippers	
Walk independently		Speech		Shoelaces	
Climbed stairs		When understandable to mother		-	-
Rode tricycle		When understandable to strangers		-	-
Catch/throw ball		-	-	-	-

Child's Social History & Current Function

Child's free time activities / interests / hobbies:

Child's current friendships/best friend:

Describe child's relationships with same age peers:

Adult interactions:

Child's showing of affection:

Child's deviant or repetitive behaviors:

Child's current self-esteem:

Child's fears:

Child's anxieties:

Child's self-help skills:

Sleep (arrangements, ease of falling asleep, etc):

☐ stays asleep ☐ nightmares ☐ bed wetting ☐ has own room ☐ shared room

Bedtime:

Feeding and Elimination issues: ☐ picky

Self-care skills (feeding, dressing, grooming):

Academic History

School attended (other than current school, list in chronological order):

Class placement

Current school:

Day care:

Pre-School:

Elementary school:

High school:

Early Intervention (dates referred to EI):

Services received:

☐ Developmental interventions
☐ Speech therapy
☐ Occupational therapy
☐ ABA
☐ Physical therapy

Child study team evaluation:

IEP (please include copy):

504 Plan:

Retentions:

Homework done daily? With help?

Tutoring/private?

Behavior therapy?

Family & Social History

Mother's age:

Mother's occupation:

Mother's level of education:

Mother's current health:

Father's age:

Father's occupation:

Father's level of education:

Father's current health:

Any history of learning problems / emotional illness / alcohol or drug use /medical problems / genetic syndromes on mother's side of family (up to 3 generations, please list below)?

Relatives:	ASD	ADHD	Learning disability	Genetic syndrome	Anxiety	Depression	Other psychiatric	Speech & language
mother								
father								
Maternal grandmother								
Maternal grandfather								
Maternal sibling								
Paternal sibling								

(If married) how long parents are married: _____

Parent's current relationships status: ☐ separated ☐ divorced

Child's Siblings:

of total siblings: _____ # of brothers: _____ # of sisters: _____

Maternal/paternal siblings: ☐ Yes ☐ No

# of siblings from maternal side: _____ # of siblings from paternal side: _____

Any siblings with developmental delays / issues? Please list below:

Siblings / Age	ASD	ADHD	Learning disability	Genetic syndrome	Anxiety	Depression	Other psychiatric	Speech & language

Home Life:

What is the primary language spoke in the home?

Are there any other family members residing in child's home?

Does the child have their own room?

Child's relationship with mother:

Child's relationship with father:

Favorite family activities:

Discipline techniques used at home?

Hours of TV / video / screen time:

Additional notes: