

PATIENT QUESTIONNAIRE

Please complete the following questionnaire to help us better understand our patients. **Bring this document to the initial appointment.**  
Thank you.

Date: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Person Completing this form: \_\_\_\_\_

Current Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

A. What concerns do you have about your child that prompted a referral to the MIND Institute and what are your goals for this evaluation?

- Diagnosis
- Recommendations for educational/behavioral interventions
- Recommendations for medical/ medication interventions
- Other

**CURRENT FAMILY SITUATION:**

Caregiver #1 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_

Relationship to child: Mother  Father  Step-Parent  Adoptive Parent  Foster Parent  Other \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Ethnic/Cultural Background: \_\_\_\_\_

Caregiver #2 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_

Relationship to child: Mother  Father  Step-Parent  Adoptive Parent  Foster Parent

Other \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Ethnic/Cultural Background: \_\_\_\_\_

With which caregiver(s) does the child live? Both  Mother  Father  Other(s) \_\_\_\_\_

If parents are separated or divorced, who has custody of this child? \_\_\_\_\_

How often does the other parent see this child? \_\_\_\_\_

Primary language spoken in the home? \_\_\_\_\_ Other languages child is exposed to? \_\_\_\_\_

Do any other adults live in the home? Yes  No  Name/age/relationship (please indicate): \_\_\_\_\_

How many children are living in the home (indicate if step-brothers/sisters or foster brothers/sisters)?

Number and ages: \_\_\_\_\_

**CHILD'S EVALUATION AND TREATMENT HISTORY**

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

Previous treatment/evaluations/diagnostic tests: (provider name/and date performed/results)

- Developmental pediatrician
- Physical Therapist
- Neurologist
- Mental Health Therapist/Counselor
- Medical doctor/specialist
- early intervention/in-home services
- Psychologist
- Regional Center
- Psychiatrist
- Behaviorist/ ABA therapy
- Speech-Language Therapist
- School district
- Occupational Therapist
- Other (If yes to any of the above, **please send us a copy of reports.**)

Diagnostic tests: (dates and results, if known)

- EEG (brain wave test) \_\_\_\_\_
- Audiology Evaluation \_\_\_\_\_
- MRI \_\_\_\_\_
- Ophthalmology Evaluation \_\_\_\_\_
- CT Scan \_\_\_\_\_
- Chromosomal/DNA testing \_\_\_\_\_
- Head Ultrasound \_\_\_\_\_
- Sleep study \_\_\_\_\_
- Blood test (other than routine blood count) \_\_\_\_\_
- Other (specify) \_\_\_\_\_

Has your child been given a specific diagnosis? If yes, please specify: \_\_\_\_\_

- Learning disability
- ADHD
- Autism/Asperger/PDD
- Speech/Language disorder
- Epilepsy
- Sensory integration
- Motor delay
- Cerebral Palsy
- Fragile X
- Tourette / tics
- Developmental Delay
- Behavior/emotional disorder
- Mental Retardation/Intellectual Disability
- Genetic syndrome:
- Other: \_\_\_\_\_

Please list all agencies and intervention services currently involved with your family (e.g. Regional Center, Healthy Start, Child Protective Services, Early Intervention, speech therapy, OT, PT, ABA, etc). Include names of contact persons and phone numbers if known: \_\_\_\_\_

**PREGNANCY**

Did mother receive prenatal care during the pregnancy? Yes  No  Starting in which month \_\_\_\_\_ Mother's age during this pregnancy \_\_\_\_\_

Previous pregnancies? Yes  (if yes, number of pregnancies, including miscarriages) \_\_\_\_\_

Did mother have any of the following during or immediately before/after the pregnancy? (Please check all that apply)

- Infections
- Anemia
- Diabetes
- Vaginal bleeding
- Bed-rest
- High blood pressure
- Threatened miscarriage
- Emotional problems
- Other (Rh incompatibility, etc.)
- Hospitalization during pregnancy? Reason: \_\_\_\_\_
- X-rays during pregnancy? What month? \_\_\_\_\_
- Were any medications or other methods used to assist with becoming pregnant? \_\_\_\_\_

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Medications prescribed during the pregnancy. Please list: \_\_\_\_\_  
Were any of the following used during this pregnancy? (Please check all that apply)  
 Tobacco  Alcohol  Marijuana  Methamphetamines  Cocaine/Crack  Heroin  Methadone  Other (specify) \_\_\_\_\_

**BIRTH HISTORY:**

Name of hospital where infant was born? \_\_\_\_\_ Was infant born full term: No  Yes   
If premature, how early \_\_\_\_\_ If overdue, how late \_\_\_\_\_  
Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ Oz. Length: \_\_\_\_\_ Head Circumference: \_\_\_\_\_  
Type of delivery:  Spontaneous  Cesarean  Induced (e.g. Pitocin)  Twins/Multiple  
 Head first  Breech (feet first)  With instruments (e.g. forceps/vacuum)  
Describe any complications during delivery: \_\_\_\_\_

Infant's APGAR scores (if known): 1 minute \_\_\_\_\_ 5 minutes \_\_\_\_\_ Did infant pass newborn hearing screening? No  Yes   
Did infant require supplemental oxygen? No  Yes  If yes, how long: \_\_\_\_\_  
Bilirubin lights (for jaundice) No  Yes  If yes, how long: \_\_\_\_\_  
Did infant have seizures? No  Yes   
Did infant have abnormal head ultrasound/scan? No  Yes   
Did infant require blood transfusions? No  Yes   
Did infant require surgery? No  Yes   
Was infant placed in the NICU? No  Yes  If yes, how long: \_\_\_\_\_  
Length of stay in hospital: Mother: \_\_\_\_\_ days Infant: \_\_\_\_\_ days

**DEVELOPMENTAL HISTORY:**

**Cognitive Development:**

Do you have concerns that your child's ability to think or learn is delayed? No  Yes   
How old does your child seem to act to you? \_\_\_\_\_

**Motor Development:**(please give age each occurred)

Age Sat alone: \_\_\_\_\_ Age Walked: \_\_\_\_\_  
Gross motor delay: No  Yes  Fine Motor Delay: No  Yes  Clumsy/uncoordinated: No  Yes   
Which hand does your child use for: Writing/Drawing? \_\_\_\_\_ Eating? \_\_\_\_\_

**Speech and Language:** (please give age each occurred)

Age spoke single words: \_\_\_\_\_ Age spoke in 3-word phrases: \_\_\_\_\_ Number of words child currently uses (vocabulary): \_\_\_\_\_  
Difficulty saying words/pronunciation? Yes  No   
Hearing concerns: Yes  No  Hearing tested? (Date& results) \_\_\_\_\_ Hearing Aide: Yes  No

**Adaptive Skills:**

**at what age?**  
Feeds self w/utensil: Yes  \_\_\_\_\_ No   
Toilet Trained: Bowel/Bladder Yes  \_\_\_\_\_ No  Accidents after training? \_\_\_\_\_  
Eating Behavior:  Normal  Picky/Restrictive diet  Gagging  Weight loss/gain  
Sleep Behavior:  No Problems  Nighttime waking  Problems falling asleep  
 Early AM waking  Loud snoring  Bedwetting  
Has child ever lost skills which at one time he/she was able to perform? Yes  No   
If yes, please explain: \_\_\_\_\_

**Social Skills:**

Does child make good eye contact? .....Yes  No   
Point to show you things? .....Yes  No   
Seek out your attention for play/fun? .....Yes  No   
Likes to play with other children? .....Yes  No   
Poor social skills compared to same age peers? .....Yes  No   
Prefers playing with children, other than siblings who are older, younger, or same age? \_\_\_\_\_  
Number of friends? \_\_\_\_\_

**Current Behavior:**

Please indicate whether your child has any of the following behaviors that are a problem. (Check all that apply)  
 Impulsive/Overactive  Destructive  Unable to separate from parent  More interested in things than in people  
 Short attention span/Distractible  Aggressive  Depressed  Rocking/spinning/hand flapping  
 Daydreaming  Mean to others/bully  Suicide thoughts  Overreacts when faced with a problem  
 Classroom disruption  Peer conflict  Strange behavior/thoughts  Requires a lot of parental attention  
 Is easily over stimulated in play  Poor school work  Psychiatric/emotional problems  Self-injurious (head bangs, bites/hits self)  
 Easily frustrated  Low self-esteem  Drug/Alcohol use  
 Doesn't follow directions  Isolated/withdrawn  Sexualized behavior  
 Oppositional/Defiant  Excessive worry/fears  Poor eye-contact

Other: Please describe any special habits, fears, or behaviors of your child: \_\_\_\_\_

**Behavior Management Methods:**

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

- Time out    Loss of allowance/privileges    Verbal Redirection    Grounding    Yelling    Physical Punishment  
 Other (specify) \_\_\_\_\_ Who is mainly in charge of discipline? \_\_\_\_\_

What do you find most difficult about raising your child? \_\_\_\_\_

**Family Changes/Stressors:**

What are the major family stressors at the present time, if any? \_\_\_\_\_

Has this child ever experienced any of the following?

- Marital discord/separation/divorce    Parent deployed overseas/out of town for work extensively  
 Birth/Adoption of another child    Financial problems    Sibling/parent illness (severe or death)    Living away from parent  
 Parents disagree about child rearing    Parent legal problems    Witness physical violence    Parent emotionally/mentally ill  
 Involved in juvenile court    Involved with Social Services/Child Protective Services    Other significant trauma/negative event

If yes to any of the above, please describe the circumstances: \_\_\_\_\_

**CHILD'S MEDICAL HISTORY:**

Date of Last Vision screening? Passed? Yes  No

Last Hearing screening? Passed? Yes  No

Does child have any **allergies** to medication/food? Yes  No  If yes, please list: \_\_\_\_\_

Is child up to date on immunizations? No  Yes  If no, which are missing? \_\_\_\_\_

Any negative reactions to immunizations? No  Yes  Describe: \_\_\_\_\_

Accidents/Injuries: Age: Type (head, abdomen, fracture, etc.): \_\_\_\_\_

Has child ever been unconscious? No  Yes  if yes, please explain: \_\_\_\_\_

Surgery/Operations: Reason: \_\_\_\_\_ Age: \_\_\_\_\_ Where: \_\_\_\_\_

Other Hospitalizations/ER visits: Age: \_\_\_\_\_ Reason: \_\_\_\_\_

Has child had any medical problems affecting the systems or organs listed below?

**System/Organ Please explain**

- Eyes Yes  No  \_\_\_\_\_  
 Ears, nose, throat Yes  No  \_\_\_\_\_  
 Heart Yes  No  \_\_\_\_\_  
 Lungs Yes  No  \_\_\_\_\_  
 Digestive (esophagus, stomach, intestines) Yes  No  \_\_\_\_\_  
 Kidneys/urinary Yes  No  \_\_\_\_\_  
 Endocrine (hormones, glands) Yes  No  \_\_\_\_\_  
 Skin Yes  No  \_\_\_\_\_  
 Blood Yes  No  \_\_\_\_\_  
 Neurologic (brain, spinal cord, trauma, seizures) Yes  No  \_\_\_\_\_  
 Psychiatric/Emotional Yes  No  \_\_\_\_\_

**Medication(s):**

Does your child take any medication: Yes  No  If more, please attach additional sheet of paper.

	Medication #1	Medication #2	Medication #3
DRUG NAME:			
PRESCRIBED BY WHOM:			
FOR WHAT PROBLEMS:			
DOSE:			
DATE STARTED / DATE STOPPED:			
BENEFITS:			
SIDE EFFECTS:			

Please list medications used in the past: \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

**Mother:** Health, learning, mental health problems? (Please specify): \_\_\_\_\_

**Father:** Health, learning, mental health problems? (Please specify): \_\_\_\_\_

Does either parent have siblings/children/pregnancies by previous or subsequent marriages? (Please list) \_\_\_\_\_

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Have any extended family members had the following problems/disorders? (Please specify who)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Birth defect                      | <input type="checkbox"/> Tics/Tourette syndrome      | <input type="checkbox"/> Obsessive Compulsive Disorder          |
| <input type="checkbox"/> Cerebral palsy                    | <input type="checkbox"/> Severe head injury          | <input type="checkbox"/> Multiple sclerosis                     |
| <input type="checkbox"/> Physical disability               | <input type="checkbox"/> Migraine headaches          | <input type="checkbox"/> Parkinson's disease                    |
| <input type="checkbox"/> Tuberosus sclerosis               | <input type="checkbox"/> Nervousness/anxiety         | <input type="checkbox"/> Seizures or epilepsy                   |
| <input type="checkbox"/> Movement Disorder                 | <input type="checkbox"/> Alzheimer's disease         | <input type="checkbox"/> Physical/Sexual abuse                  |
| <input type="checkbox"/> Alcohol/drug abuse                | <input type="checkbox"/> Muscular dystrophy          | <input type="checkbox"/> autoimmune disorder                    |
| <input type="checkbox"/> Schizophrenia                     | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Emotional disturbance/                 |
| <input type="checkbox"/> Autism/PDD/Asperger               | <input type="checkbox"/> Mental retardation/         | <input type="checkbox"/> Mental Illness                         |
| <input type="checkbox"/> ADHD                              | <input type="checkbox"/> Intellectual disability     | <input type="checkbox"/> Failed to graduate from high school    |
| <input type="checkbox"/> Speech/language delay             | <input type="checkbox"/> Reading problem/Dyslexia    | <input type="checkbox"/> Developmental delay                    |
| <input type="checkbox"/> Bipolar/manic-depressive disorder | <input type="checkbox"/> other learning disabilities | <input type="checkbox"/> Chromosomal disorder /genetic syndrome |
| <input type="checkbox"/> Childhood behavior disorder       | <input type="checkbox"/> Antisocial behavior         |   |
| (Aggressive/defiant/oppositional)                          | (Assaults, thefts, arrests)                          |   |

Other: \_\_\_\_\_

Have any family members ever received extra help in school, early intervention, or special education services? Yes  No

If yes, please specify reason? \_\_\_\_\_

**CHILD'S EDUCATIONAL HISTORY:**

Name of current school: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Teacher's name: \_\_\_\_\_ Grade: \_\_\_\_\_

**Intervention/School History:**

Early Intervention/In-home (0-3 years)? No  Yes  Age? \_\_\_\_\_ Name of program: \_\_\_\_\_

Preschool/Head Start? No  Yes  Age? \_\_\_\_\_ Name of program: \_\_\_\_\_

Elementary/Middle school? No  Yes  Age? \_\_\_\_\_ Name of school(s): \_\_\_\_\_

Has child ever repeated a grade? No  Yes  if yes, what grade: \_\_\_\_\_

Does child like going to school? No  Yes

Has child ever been suspended or expelled? No  Yes

Is child late or absent from school frequently? No  Yes  Reason: \_\_\_\_\_

Has the school raised concerns about your child's learning or behavior? \_\_\_\_\_

**School Assessments and Intervention:**

Has child had special education testing in school?

Psychological/Cognitive No  Yes  Date: \_\_\_\_\_ Academic (RSP) No  Yes  Date: \_\_\_\_\_

Speech/Language No  Yes  Date: \_\_\_\_\_ Other: \_\_\_\_\_ No  Yes  Date: \_\_\_\_\_

Is your child on an IEP (Individual Education Plan) or IFSP? No  Yes  Reason? \_\_\_\_\_

**\*\*\*IMPORTANT: Please fax or mail all evaluation reports and IEP as soon as possible to (916) 703-0350\*\*\***

**CHILD'S STRENGTHS:**

Please tell us what activities your child likes or does well. What do you enjoy most about your child?

\_\_\_\_\_  
\_\_\_\_\_

Thank you for taking the time to tell us about your child and family. Please bring this questionnaire, all evaluation reports, and school records/IEP with you to:

**MIND Institute Clinics  
UC Davis Health System  
2825 50<sup>th</sup> Street  
Sacramento, CA 95817**