



COLLABORATIVE MOTOR CLINIC
NAVAL MEDICAL CENTER PORTSMOUTH
NEURODEVELOPMENTAL PEDIATRICS
NEW PATIENT QUESTIONNAIRE



Dear Parents and Caregivers,

Welcome to Neurodevelopmental Pediatrics! Please complete this form to help us understand your questions and concerns about your child. Thank you for your efforts-this will be helpful during your visit. If there are questions you aren't sure about, just do the best you can.

Child's Name: _____ Your name: _____
Child's Date of Birth: _____ Today's Date: _____
Child's PCM: _____ Phone Number: _____
Child's School or School District: _____
Email we may use to contact you:

If your child has been evaluated before, **please bring all evaluations with you.** This is *very important* and will help us to provide an accurate and appropriate evaluation for your child.

- Psychological/School testing
- Occupational, Physical, and Speech Therapy Evaluations
- Individual and Family Service Plans
- Individualized Education Plans
- Medical Evaluations (especially from civilian providers)

REASONS FOR EVALUATION

Please list the problems, questions or concerns for which you want help for your child:

What are your goals for today's visit?

CURRENT ABILITIES/FUNCTIONING

Mobility:

How does your child get around?:

At home:

In the community:

Spasticity:

Is your child having difficulty with stiffness or muscle tightness? Yes No

Location:

Has your child ever been treated for spasticity and what was the response?

Medication Yes No Response:

Botox Yes No Response:

Surgery Yes No Response:

Bracing Yes No Response:

Activities of Daily Living:

How does your child meet basic needs for dressing/bathing?:

- Dependent for all care
- Needs assistance
- Independent

How does your child use the toilet?:

- Diapered. If so, where do you get diapers?:
- Uses toilet with help
- Uses toilet independently

How does your child eat?:

- By mouth fed by another person
- By mouth independently
- By mouth and tube
- By gastrostomy/jejunostomy/nasogastric tube (circle one)
- Other:

Is there any choking or coughing associated with eating or drinking: Yes No

How does your child communicate wants and needs?

- Noises
- Words
- Signs
- Facial Expressions

What concerns do you have about your child's language ability?:

- Understanding spoken directions
- Expressing him/herself verbally
- Speaking clearly
- Back and forth conversation skills

Participation: What activities does your child enjoy or participate in at home or in the community?

Education: Are you or your child's teachers concerned about your child's ability to learn new information or to perform at school/daycare? Yes No

Specify:

Does your child currently have any of the following?:

- Individual and Family Service Plan
- Individualized Education Plan
- 504 plan

Therapies:

Check therapies your child receives at school and in the community:

	School/Early Intervention	Community (List Agency)
Physical		
Occupational		
Speech		
Other		

Do you have concerns about social development/behavior (please specify):

- Social skills/Friendships:
- Activity level/Attention and concentration:
- Aggression towards self/others:
- Anxiety/Sadness:

Adaptive equipment:

Does your child need any adaptive equipment at this time?

What adaptive equipment does your child use at this time (please specify):

- Splints/braces:
- Wheelchair/Stroller:
- Walker:
- Stander:
- Bath chair:
- Communication device:

Military and community supports:

Does your child have any of these supports?:

- Enrollment in Exceptional Family Member Program (EFMP)
- Enrollment in ECHO
- Case management: Please provide name and agency:
- Respite care
- Medicaid
- SSI

Transition to adulthood:

What concerns do you have about your child as he/she approaches adulthood?

DEVELOPMENTAL HISTORY

When were you first concerned about your child's development?

Has your child ever **lost** any skills? Yes No (If yes, please explain):

When did your child first do the following?

Motor skills	Age	Language	Age
Sat unsupported		Coo	
Crawled		Babble	
Walked alone		Wave bye-bye	
Pedaled Tricycle		Said "mama/dada"	
Bicycle with/without training wheels	/	2-word combinations/3-word sentences	/
Self-Care	Age	Learning	Age
Fed self with a spoon		Knew colors	
Removed clothes		Recited alphabet	
Put on clothes		Wrote name	
Toilet trained			
Tied shoes			

Temperament: these questions are about **how** your child has since birth:

Activity level <input type="checkbox"/> Always moving and active <input type="checkbox"/> Still and calm Sleep, appetite, bowels <input type="checkbox"/> Predictable <input type="checkbox"/> Less Predictable Adaptation to changes in routine or daily activities <input type="checkbox"/> Flexible <input type="checkbox"/> Inflexible React to new people or unfamiliar situations <input type="checkbox"/> Warms up with time <input type="checkbox"/> Warms up quickly Sensitivity to: sounds, touch, clothing <input type="checkbox"/> Sensitive <input type="checkbox"/> Less sensitive	Intensity of feelings or emotions (either positive or negative) <input type="checkbox"/> Intense response <input type="checkbox"/> More reserved response Distractibility <input type="checkbox"/> Easily changes focus <input type="checkbox"/> Pays attention Usual mood <input type="checkbox"/> Pleasant and cheerful <input type="checkbox"/> More critical/analytical Persistence <input type="checkbox"/> Sticks with tasks/activities <input type="checkbox"/> Moves on if tasks are difficult or frustrating
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MEDICAL HISTORY

Early Medical History (Pregnancy, Birth, Infancy)	
Pregnancy	
<p>Was there any difficulty getting pregnant or any fertility treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> • Please list the treatments used: <p>Number of prior pregnancies: _____</p> <p>Mother's age during pregnancy: _____</p> <p>Father's age during pregnancy: _____</p> <p>When did prenatal care begin?</p> <p><input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester <input type="checkbox"/> No prenatal care</p> <p>Length of pregnancy:</p> <p>Were there any complications during pregnancy?</p> <p>Mother's weight gain during pregnancy: <input type="checkbox"/> too little <input type="checkbox"/> just right <input type="checkbox"/> too much</p> <p>Mother's health during pregnancy: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Please list ALL medications/supplements taken during pregnancy:</p>	<p>Did mother drink alcohol or use drugs in the months prior to discovering pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list amount per day of the following <i>during pregnancy</i>:</p> <p>Beer or wine: Hard liquor: Cigarettes: Drugs (specify):</p> <p>Did mother have any of the following problems during pregnancy (check):</p> <p><input type="checkbox"/> Vaginal bleeding or spotting <input type="checkbox"/> Prenatal monitoring or test (amnio, stress test, ultrasound) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes <input type="checkbox"/> Fever, Rash, Infection (Rubella, CMV, HIV) <input type="checkbox"/> Serious Injury or Surgery <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Stresses or worries (Specify):</p> <p><input type="checkbox"/> Other problems:</p> <p>Baby's movements in utero were: <input type="checkbox"/> very little <input type="checkbox"/> average <input type="checkbox"/> very active</p>

Labor and Delivery/Neonatal Period	
<p>Labor: How long was labor?</p> <p>Were there complications during labor or delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Premature rupture of membranes <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Forceps/vacuum <input type="checkbox"/> Baby required oxygen or resuscitation <input type="checkbox"/> Failure to progress <input type="checkbox"/> Maternal fever <input type="checkbox"/> Other problems: <p>Type of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section</p> <p>Baby's position</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head down (vertex) <input type="checkbox"/> Legs or bottom down (breech) <p>Birth Weight _____ Length _____ Head circumference _____</p> <p>How long did your baby stay in the hospital after birth?</p>	<p>How long did the mother stay in the hospital after birth?</p> <p>Did the baby spend time in the NICU? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems in the newborn period?</p> <p>Did your baby pass a <u>newborn hearing test</u>? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Feeding</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast Fed until <input type="checkbox"/> Bottle Fed until <input type="checkbox"/> Difficulty with feeding (please explain): <p>Was there a history of post-partum depression? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe, not officially diagnosed</p> <p>What was the child like as a baby (easy to soothe, difficult to soothe, content, fussy, irritable, challenging, quiet...)</p>
Childhood Medical History	
<p>Has your child had any chronic or severe illnesses or medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list and explain:</p> <ol style="list-style-type: none"> 1. 2. 3. <p>Has your child ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please explain:</p> <p>Has your child ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please explain:</p>	

<p>Allergies (medication, food, environmental, seasonal): <input type="checkbox"/> No allergies <input type="checkbox"/> Allergies to:</p>
<p>Are immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not?</p>
<p>Medications Please list your child's current medications: 1. 2. 3. 4.</p>
<p>Review of Systems</p>
<p>Nutrition: Are you concerned about your child's eating habits or growth?: <input type="checkbox"/> No <input type="checkbox"/> Yes Please check specific concerns: <input type="checkbox"/> Eats too much <input type="checkbox"/> Eats too little <input type="checkbox"/> Too picky <input type="checkbox"/> Other:</p>
<p>Sleep: Does your child have any trouble with sleep?: <input type="checkbox"/> Yes <input type="checkbox"/> No What time does your child get in bed? _____ What time does your child fall asleep? _____ Does your child wake up during the night? <input type="checkbox"/> No <input type="checkbox"/> Yes Is there snoring? <input type="checkbox"/> No <input type="checkbox"/> Yes Are there pauses in breathing <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Elimination: How often does your child have a bowel movement? _____</p> <p>Is it: <input type="checkbox"/> Too hard <input type="checkbox"/> Too soft <input type="checkbox"/> Average</p> <p>Are there any accidents with stooling? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Does your child have any trouble with urination or bladder problems? <input type="checkbox"/> No <input type="checkbox"/> Yes Please check specific concerns: <input type="checkbox"/> Accidents during the day <input type="checkbox"/> Accidents at night <input type="checkbox"/> Other:</p>

Does your child have (check if yes and please explain):

- Skin problems
- Birth marks
- Bone/muscle/joint problems
- Headaches
- Seizures
- Head too small/too big/odd shape?
- Vision/eye problems?
- Hearing/ear problems?
- Nose problems?
- Breathing problems (wheezing, cough or other)
- Neck Problems
- Stomach/Intestinal problems?
- Other:
- CHECK HERE IF YOUR CHILD HAS NONE OF THE PROBLEMS LISTED ABOVE

SOCIAL HISTORY:

<p>Mother's Name: _____ Date of Birth: _____ Education Level: _____ Occupation: _____ Marital Status: _____</p>	<p>Father's Name: _____ Date of Birth: _____ Education Level: _____ Occupation: _____ Marital Status: _____</p>
<p>Who lives with the child at home? (Name, Age, Relationship:</p> <ol style="list-style-type: none"> 1. 2. 3. 4. 5. 	<p>What are stresses or family problems since your child has been born (moves, deployments, marital conflicts, financial problems, etc.):</p> <ol style="list-style-type: none"> 1. 2. 3.

FAMILY HISTORY:

Does anyone in the family have any of the following (check all that apply, past or present) :					
	Mother	Father	Sibs	Mother's side	Father's side
Intellectual Disability/Mental Retardation					
Learning Disabilities					
Attention problems; hyperactivity ("ADD/ADHD")					
Depression					
Anxiety Disorders					
Manic Depression/Bipolar Disorder					
Schizophrenia					
Heart problems/Sudden death from heart problems/heart rhythm problems/high blood pressure					
Emotional or behavioral disturbance					
Autism, PDD, Asperger Syndrome					
Birth defects, genetic syndromes					
Cerebral palsy					
Visual impairment (apart from just glasses for distance or reading)					
Hearing problems/hearing loss					
Other (Describe)					
PLEASE CHECK THIS ROW IF NONE OF THE ABOVE					

Is there anything else you would like to make sure we know about your child?

Thank you for your time!

-The Collaborative Motor Clinic Team