



**NAVAL MEDICAL CENTER PORTSMOUTH
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 School or School District: _____

Phone Number: _____

Email:

(If you give us your email, you are giving us permission to contact you by email)

PART I - REASONS FOR EVALUATION

Please list the problems, questions or concerns for which you want help for your child. When did you first notice these problems?

What are your goals for today's visit?

Has your child been evaluated for these problems before? If you have evaluation results (testing, IFSP, IEP, medical reports), please give them to the front desk staff as soon as you arrive.

Part II-BEHAVIORAL CONCERNS

Does your child:

	Yes	No	Comments:
Get along with children his/her age?			
Enjoy playing with others vs. alone?			
Make and keep friends easily?			
Make eye contact when appropriate?			
Engage in pretend play?			

	Yes	No	Comments
Have any repetitive motor movements (flapping, spinning, jerking)?			
Have a variety of interests that are typical for age?			
Insist on sameness in routine?			
Get easily frightened or bothered by sounds			
Get easily bothered by things touching him or her?			
Have unusual fears or worries?			
Seem hyperactive compared to peers?			
Seem inattentive compared to peers?			
Seem unusually oppositional or argumentative?			
Hurt self or others?			

Part III – DEVELOPMENTAL HISTORY

How old was your child when you or a family member first became concerned about your child's development? Why?

Has your child ever **lost** any skills? Explain/describe:

When did your child first do the following: (do the best you can. If you can't remember it's ok to write *early*, *on time*, or *late!*)

Motor skills	Age	Language	Age
Sat unsupported		Coo	
Crawled		Babble	
Walked alone		Wave bye-bye	
Pedaled Tricycle		Said "mama/dada"	
2 wheeler with training wheels		Put 2 words together	
2 wheeler without training wheels		Put 3 words together	
Self Care	Age	Learning	Age
Unressed		Knew colors	
Dressed		Recited alphabet	
Fed self with a spoon		Wrote name	
Toilet trained			
Tied shoes			

Part IV– TEMPERAMENT

These questions are about what your child is like and has been like **most of his/her life**:

<p>Activity level</p> <ul style="list-style-type: none"><input type="checkbox"/> Always moving and active<input type="checkbox"/> Still and calm <p>Sleep, appetite, bowels</p> <ul style="list-style-type: none"><input type="checkbox"/> Easy to predict and get on a schedule<input type="checkbox"/> Hard to predict and get on a schedule <p>Adaptation to changes in routine or daily activities</p> <ul style="list-style-type: none"><input type="checkbox"/> Flexible<input type="checkbox"/> Inflexible <p>React to new people or unfamiliar situations</p> <ul style="list-style-type: none"><input type="checkbox"/> Slow to warm up<input type="checkbox"/> Warms up quickly <p>Sensitivity to: sounds, touch, clothing</p> <ul style="list-style-type: none"><input type="checkbox"/> Easily bothered<input type="checkbox"/> Laid back	<p>Intensity of feelings or emotions (either positive or negative)</p> <ul style="list-style-type: none"><input type="checkbox"/> Intense response<input type="checkbox"/> More reserved response <p>Distractibility</p> <ul style="list-style-type: none"><input type="checkbox"/> Trouble paying attention<input type="checkbox"/> Pays attention <p>Usual mood</p> <ul style="list-style-type: none"><input type="checkbox"/> More often pleasant and cheerful<input type="checkbox"/> More often hard to please, whiny, unhappy, irritable, complaining <p>Persistence</p> <ul style="list-style-type: none"><input type="checkbox"/> Sticks with a difficult activity before giving up, completes tasks<input type="checkbox"/> Gives up quickly when things get difficult, doesn't complete tasks
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Part V – CURRENT ABILITIES/FUNCTIONING

If you had to guess, what age child does your child most act like? _____

What do you enjoy most about your child?

How would you rate your child's overall intelligence?

- Below Average
- Average
- Above Average

Motor Skills: Are you concerned about your child's movement: No Yes

Please check specific concerns:

- Athletic ability
- Throwing/Catching
- Running/Jumping
- Balance

Language: Are you concerned about your child's language: No Yes

Please check specific concerns:

- Understanding spoken directions
- Expressing him/herself verbally
- Speaking clearly
- Other:

Fine motor and adaptive skills: Are you concerned about your child's ability to take care of him/herself and use his/her hands: No Yes

Please check specific concerns:

- Tying shoes
- Dressing
- Zipping/buttoning/fastening
- Bathing/ performing self hygiene
- Other:

Nutrition: Are you concerned about your child's eating habits: No Yes

Please check specific concerns:

- Eats too much
- Eats too little
- Too picky
- Other:

Sleep: Does your child have any trouble with sleep: No Yes

What time does your child get in bed?

What time does your child fall asleep?

Does your child wake up during the night? No Yes

Are there snoring or pauses in breathing No Yes

How often does your child have a bowel movement? _____

Is it:

- Too hard
- Too soft
- Just right

Does your child have any trouble with bladder or urination? No Yes

Please check specific concerns:

- Accidents during the day
- Accidents at night
- Other:

Part VI – SCHOOL HISTORY

Has your child ever been in special education or early intervention services? No Yes
(please list years and services):

Has your child ever been home schooled: No Yes

List years:

Where does your child go to school now? _____

Is there a current IFSP, IEP, IAT? No Yes

Has there been any previous psycho-educational testing (IQ, achievement tests)?
 No Yes

Do you or your child's teachers have any concerns about how your child's academic performance in school compared with others of the same age? No Yes

Check if your child has difficulty with the following:

- Reading
- Spelling
- Math
- Completing homework
- Study skills
- Organizational skills
- Overall learning
- Failing grades
- Trouble staying on task or paying attention
- Problems with behavior
- Expulsion/suspension

Do you or your child's teachers have any concerns about your child's behavior or social skills at school? No Yes

What is being done to work on these problems:

PART VII- MEDICAL HISTORY

Section A – 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> <p>When did prenatal care begin?: <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 health during pregnancy: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</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>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: Beer or wine: Hard liquor: Cigarettes: Drugs (specify):</p> <p>Did mother have any of the following problems during pregnancy (check):</p> <ul style="list-style-type: none"> <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><input type="checkbox"/> Other problems:</p> <p>Baby’s movements in utero were: <input type="checkbox"/> too little <input type="checkbox"/> just right <input type="checkbox"/> too much</p>

Labor and Delivery/Neonatal Period	
<p>Labor: How long was labor?</p> <p>Were there complications during labor or delivery?</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>Mother's age at delivery: Father's age at delivery:</p> <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>Feeding</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast Fed until <input type="checkbox"/> Bottle Fed <input type="checkbox"/> Difficulty with feeding (please explain): <p>Was there a history of post-partum depression? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Maybe, not officially diagnosed</p> <p>Was the baby:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Easy to soothe <input type="checkbox"/> Hard to soothe <input type="checkbox"/> Colicky <input type="checkbox"/> Other:
Section B –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):</p> <p><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: why not?:</p>														
<p>Equipment: Does your child use any specialized equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Orthotics <input type="checkbox"/> Stander <input type="checkbox"/> Communication device <input type="checkbox"/> other</p>														
<p>Section C-Review of Systems</p>														
<p>Does your child have (check if yes and please explain):</p> <table border="0"> <tr> <td><input type="checkbox"/> Skin problems</td> <td><input type="checkbox"/> Hearing/ear problems?</td> </tr> <tr> <td><input type="checkbox"/> Birth marks</td> <td><input type="checkbox"/> Nose problems?</td> </tr> <tr> <td><input type="checkbox"/> Bone/muscle/joint problems</td> <td><input type="checkbox"/> Breathing problems (wheezing, cough or other)</td> </tr> <tr> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Neck Problems</td> </tr> <tr> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Stomach/Intestinal problems?</td> </tr> <tr> <td><input type="checkbox"/> Head too small/too big/odd shape?</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Vision/eye problems?</td> <td></td> </tr> </table>	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Hearing/ear problems?	<input type="checkbox"/> Birth marks	<input type="checkbox"/> Nose problems?	<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Breathing problems (wheezing, cough or other)	<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stomach/Intestinal problems?	<input type="checkbox"/> Head too small/too big/odd shape?	<input type="checkbox"/> Other:	<input type="checkbox"/> Vision/eye problems?	
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Part VIII-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, family violence, abuse, illnesses or deaths, financial problems, alcohol or drug problems, etc.):</p> <ol style="list-style-type: none"> 1. 2. 3.

Part IX– 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					
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)					

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

Thank you for your time!

The Neurodevelopmental Pediatrics Team.