



Kaiser Permanente Santa Clara Medical Center  
Department of Pediatrics  
710 Lawrence Expressway #190  
Santa Clara, CA 95051  
(408) 851-9896

Dear Parent:

Your child has been referred for a developmental pediatrics evaluation. This is because you, or your physician, have expressed some concerns about your child's progress in one or more areas of development, such as speech and language, walking and motor skills, school performance, or behavior.

This evaluation will be done by our developmental pediatrician, Dr. Mark Cohen. It will usually be completed in one visit, but sometimes a follow-up visit may be needed.

To make this evaluation most helpful, we need to obtain information about your child's health, developmental progress, and behavior, as well as his or her strengths and weaknesses in a number of areas. In order to make the best use of your time and ours, we ask that you provide us with some of this information beforehand, by completing this Child Development Questionnaire, and returning it to us before your child's appointment.

Yes, the questionnaire is long and involved, but it is very important that you answer it completely. If you don't know the answer to any question, write "Unknown." If a question does not apply to your child, write "N/A." If there are some things you would prefer discussing in person with the physician, just note that on the form.

**Please bring the completed questionnaire with you to your visit.** If you do not, you may be asked to fill out the questionnaire again.

Please feel free to call us at (408) 851-9896 if you have difficulty completing the form, or if you have any questions.

Thank you for helping us to provide the best care for your family.

**CHILD DEVELOPMENT QUESTIONNAIRE**

Department of Pediatrics  
Kaiser Permanente Santa Clara Medical Clinic

**This information is a very important part of your child's developmental evaluation.  
Please answer all questions as completely as you can.  
If you need more space to answer any question, please use the last page of the questionnaire.**

Child's full name \_\_\_\_\_ Kaiser No. \_\_\_\_\_

Child's birthdate \_\_\_\_\_ Age \_\_\_\_\_ Today's date \_\_\_\_\_

Name of person(s) completing this form \_\_\_\_\_

Relationship to child \_\_\_\_\_

What does your child like to be called? \_\_\_\_\_

Child's school (or preschool) \_\_\_\_\_ Grade \_\_\_\_\_

Who referred you for this evaluation? \_\_\_\_\_

Father's name \_\_\_\_\_ Biological \_\_\_\_\_ Adoptive \_\_\_\_\_ Stepfather \_\_\_\_\_

Age \_\_\_\_\_ School level completed \_\_\_\_\_ Employment \_\_\_\_\_

Ethnic background (optional) \_\_\_\_\_

Mother's name \_\_\_\_\_ Biological \_\_\_\_\_ Adoptive \_\_\_\_\_ Stepmother \_\_\_\_\_

Age \_\_\_\_\_ School level completed \_\_\_\_\_ Employment \_\_\_\_\_

Ethnic background (optional) \_\_\_\_\_

Current marital status of parents (circle one)

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Living together \_\_\_\_\_ Other \_\_\_\_\_

Date of marriage \_\_\_\_\_ Date of divorce/separation \_\_\_\_\_

With whom does the child live? (e.g., both parents, step-parent, father, mother, grandparent, foster parents, etc.) \_\_\_\_\_

Who cares for the child during the day if the parents work?  
\_\_\_\_\_

Phone number: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**WHAT ARE YOUR CONCERNS?**

**Please list the concerns you have about your child.** If there are things that concern other people (such as grandparents, a doctor, etc.) but that you think are OK, please include them, but check "Not concerned."

Problem	Age noted	Diagnosis (if known)	NotConcerned
1. _____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	<input type="checkbox"/>
4. _____	_____	_____	<input type="checkbox"/>

**Do you have any other concerns about your child's development or behavior?**

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**Has your child had any evaluation, testing, or treatment related to these concerns?**

Date	Location	Diagnosis/What were you told?/What was done?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MOTHER'S PREGNANCY HISTORY**

(If the child's mother is not completing this form, please provide as much information as possible)

Child's full name	Date of birth	Health or Developmental Problems?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**MOTHER'S PRENATAL HISTORY**

(If the child's mother is not completing this form, please provide as much information as possible)

Did you take vitamins and iron during this pregnancy?    Y                     N

Please list any other medications or drugs taken during this pregnancy, including supplements

\_\_\_\_\_

Did you smoke cigarettes during this pregnancy?                    Y                     N

Did you drink alcohol before and/or during this pregnancy?    Y                     N

If you stopped during your pregnancy, in which month did you stop? \_\_\_\_\_

Please describe any problems with the pregnancy:

\_\_\_\_\_

\_\_\_\_\_

Was the child born within two weeks of your due date?    Y                     N

If not:    \_\_\_\_\_ weeks early                    \_\_\_\_\_ weeks late                    Gestational age, if known \_\_\_\_\_

How long was your labor? \_\_\_\_\_ How was your child delivered? \_\_\_\_\_

Please describe any problems with the delivery:

\_\_\_\_\_

\_\_\_\_\_

**YOUR CHILD'S BIRTH** (Include as much information as you know.)

Birth weight \_\_\_\_\_ Length \_\_\_\_\_ Head circumference \_\_\_\_\_ Apgar scores \_\_\_\_\_

**Please describe your child's condition at birth and in the nursery**

	Y	N	Explain
Breathed immediately			
Cried immediately			
Required resuscitation in the delivery room			
Had seizures/convulsions			
Had infection (blood, pneumonia, etc.)			
Low blood sugar			
Jaundice			
Phototherapy (special lights) for jaundice			
Fluids or medications by IV or catheter			
Fed by tube through nose or mouth			
Needed help with breathing (CPAP or ventilator)			

Went home at \_\_\_\_\_ days of age. Home with mother? Y  N

Any other problems in the newborn period? (For example, surgery, transfer to another hospital, special tests, etc.)

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**YOUR CHILD'S NUTRITION**

Breast fed? Y  N  How long? \_\_\_\_\_

Formula fed? Y  N  How long? \_\_\_\_\_

**Any difficulties with feeding as an infant?** (Slow feeder, choking, difficulty swallowing, food intolerance, food allergy, colic, etc.) Y  N   
If so, please explain:

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**Were there concerns about how well the baby was gaining weight?** Y  N   
If so, please explain:

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**Do you have any concerns about your child's eating or nutrition now?** Y  N   
If so, please explain:

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**YOUR CHILD'S HEALTH**

Who is your child's regular physician? \_\_\_\_\_

What other physicians or therapists does your child see regularly (including counseling or mental health practitioners)?

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Does your child have a diagnosed medical condition, syndrome, or disorder? Y  N   
If so, please describe:

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When was your child's last well child visit (checkup)? \_\_\_\_\_

Is your child missing any immunizations? Y  N

**Please circle any of the following conditions that your child has, or had in the past.**

Frequent ear infections; frequent colds; pneumonia; bronchitis; asthma; chronic diarrhea; chronic skin problems; frequent vomiting; seizures; meningitis; headaches; breath-holding spells; loss of consciousness; head injury; broken bones; limp; difficulty walking; drooling; joint problems; arthritis; anemia; muscle problems; eye problems; constipation; hearing problems; dental problems; poor weight gain; eating non-food items; heart disease; kidney disease; thyroid disease; severe reaction to medication, immunization, or injection; large or multiple birthmarks; major or minor surgery; hospitalized overnight

Please explain any of the above, or list other medical diagnoses or conditions:

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Has your child's hearing been tested? Y  N  Result \_\_\_\_\_

Has your child's vision been tested? Y  N  Result \_\_\_\_\_

**Is your child currently taking any medication?** Y  N

Medication	Dose	Reason/ Condition	Does it help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child take any over-the-counter medications, nutritional supplements, or other treatments on a regular basis? Y  N  \_\_\_\_\_

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### **YOUR CHILD'S EARLY DEVELOPMENT**

**Please note the age at which your child first did each of the following.** Please try to be as accurate as possible, by using baby books, asking relatives, etc. Put "not yet" if he/she does not do this.

Sat up without help \_\_\_\_\_ Crawled \_\_\_\_\_ Walked alone \_\_\_\_\_

Used a spoon \_\_\_\_\_ Drank from regular cup \_\_\_\_\_

Said first word \_\_\_\_\_ Put two words together ("my ball," "mommy go") \_\_\_\_\_

Recited alphabet \_\_\_\_\_ Counted to ten \_\_\_\_\_ Read words \_\_\_\_\_

**Has your child lost any skills?** (Are there things that he/she used to be able to do but doesn't or can't do anymore?) Y  N  Explain \_\_\_\_\_

## **YOUR CHILD'S BEHAVIOR**

### **EARLY BEHAVIOR :**

Please note if any of the following were a problem or concern during the first 2 years of your child's life:

	Not a problem	Mild or occasional problem	Big problem
1. Feeding difficulties			
2. Sleeping difficulties			
3. Rhythmic behaviors (i.e. head banging)			
4. Hard to console or comfort			
5. Floppy			
6. Excessive crying			
7. Not interested in other people			
8. Not affectionate			

Explain: \_\_\_\_\_

### **PRESENT BEHAVIOR**

**(Skip this section if your child is less than 2 years old.)**

Please note if any of the following are a problem or concern for your child now, more than for other children his/her age.

	Not a problem	Mild or occasional problem	Big problem
1. Sensitive, cries easily			
2. Often seems confused			
3. Sleeps poorly			
4. Often tired			
5. Demands attention			
6. Often sad			
7. Often wets pants or bed			
8. Bowel movement accidents			
9. Sucks thumb or other objects			
10. Refuses to obey			
11. Tells lies frequently			
12. Very shy			
13. Temper tantrums			
14. Hurt people or damaged property			
15. Anxious or nervous			
16. Uses peculiar speech			
17. Cruel to animals			
18. Unusual fears			
19. Difficulty making or keeping friends			
20. Nervous habits or tics			

Please explain any of the above: \_\_\_\_\_

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

### **FAMILY HISTORY**

Child's biological father:

School level completed \_\_\_\_\_ Present occupation \_\_\_\_\_

Child's biological mother:

School level completed \_\_\_\_\_ Present occupation \_\_\_\_\_

Are this child's parents blood-related? Y

N

**Please indicate if any family members have had:**

Condition	Child's Father	Child's Mother	Child's Brother(s)	Child's Sister(s)
1. Speech problems				
2. Hyperactive as a child				
3. Problems with coordination				
4. Difficulty learning to read				
5. Difficulty with spelling				
6. Difficulty with arithmetic				
7. Special education				
8. Behavior problems as a child				
9. In trouble as a teenager				
10. Kept back in school				

**Please indicate if any family members (including grandparents, aunts, uncles, etc.) have had any of the following:**

Condition	Y	N	Relation to child	Deceased
1. Mental retardation				
2. Mental illness or disorder				
3. Birth defects				
4. Seizures/convulsions				
5. Neurological disorder				
6. Muscle disease				
7. Genetic disorder				
8. Thyroid disorder				
11. Hearing problem				
13. Death in infancy				

Please give details if known: \_\_\_\_\_

\_\_\_\_\_

**YOUR CHILD'S SCHOOL**

**(Skip this section if your child is not yet attending school)**

Present school: \_\_\_\_\_ Location \_\_\_\_\_

Principal: \_\_\_\_\_ Teacher \_\_\_\_\_

Home schooled?    Y         N

If so, which curriculum do you use? \_\_\_\_\_

Has your child ever repeated a grade?    Y         N         Which one? \_\_\_\_\_

Is your child receiving special education services, or was he/she in the past?    Y         N

If so, please explain:

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Have you ever been told that your child was having problems in school?        Y         N

If so, please explain what you were told and what was (or is being) done:

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**If your child has been having problems in school, please bring any school reports you have when you come for the developmental pediatrics evaluation.**

This includes:

- Report cards
- IEP's
- Teacher reports
- Standardized test results: Cognitive (IQ), Achievement, Adaptive, etc.

**SUMMARY**

Please tell us your main concern(s) about your child.

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Is there anything that you think (or wonder) might have caused or contributed to the problem?

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What are your hopes and goals for your child?

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What do you think needs to be done in order to help your child achieve these goals?

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What do you think we might be able to offer you and your child?

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Is there anything that has not been covered in this questionnaire that you would like us to know, or that you think may be important regarding your child?

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(Please feel free to use the next page to give a more complete answer to any question.)

**Thank you very much for taking the time to complete this questionnaire.**

Please call us at (408) 851-9896 if you have any questions.

**IMPORANT:**

**PLEASE BRING THIS QUESTIONNAIRE TO YOUR CHILD'S APPOINTMENT**

## **Additional Comments**