PLACE PATIENT LABEL HERE

UC DAVIS HEALTH
MIND INSTITUTE CLINICS

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? _____

❒ 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) _____

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

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

❒ 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:

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