UMass Memorial
Children's Medical Center

Developmental and Behavioral Pediatrics (DBP)

Please attach a photo of your child

DBP Mailing address:
ATT: DBP Admin
Suite S4-301 Room S4-301C46
55 Lake Avenue North
Worcester, MA 01655
Phone: 508-334-8728
Fax: 774-455-4229

DBP clinic:
Benedict Building, second floor
55 Lake Avenue North
Worcester, MA01655

Parent Questionnaire
For children, older than 5 years old

PLEASE NOTE: **We are unable to provide emergency services. If you are concerned that your child is in immediate danger of harming himself/herself or others, contact 911, an emergency service provider, and/or your child's primary care provider.**

Check our website for any questions: www.umassmemorial.org/DBP

*******PLEASE COMPLETE AND MAIL QUESTIONNAIRE BACK TO US WITHIN 3 MONTHS***********

I. GENERAL INFORMATION

Name of person(s) completing form:_____ **Date completed:** _/___/____

CHILD'S NAME:	**Last Name:**			**First Name:**	
Date of birth:	/ /	**Age:**		❑ **Male**	❑ **Female**
Parent 1 name / date of birth				/ /	
Parent 2 name / date of birth				/ /	
Home address:					
Phone numbers:	**H:**			**C:**	
Email:					
Second home address & phone: (specify parent):					
Email:					
Child's primary language:					
Parent's primary language:				**Interpreter needed?** ❑ **Yes** ❑ **No**	
Who has legal custody of child?	❑ Mother ❑ Father ❑Grandparents ❑ DCF ❑Other (specify):				

CHILD'S PRIMARY DOCTOR:		
Doctor's address & phone #:		**#:**
OTHER PHYSICIANS INVOLVED:		
❑ **Neurologist:**		**#:**
❑ **Psychiatrist:**		**#:**
❑ **Developmental Behavioral Pediatrician:**		**#:**

CURRENT SCHOOL/PROGRAM:		
School Address and number:		**#:**
Contact Person and number:		**#:**

II. PRESENTING CONCERNS: Please check the reasons that you are seeking an evaluation of your child at this time. Indicate the level of your concern by circling the number next to it that best fits.

√	Presenting Concerns	Mildly concerned 1	Somewhat concerned 2	Very concerned 3	Extremely concerned 4
❑	Learning problems with reading, writing, spelling and/or math.	1	2	3	4
❑	Do not agree with the school over whether my child needs services, and/or what type of services are needed.	1	2	3	4
❑	Problems paying attention, staying focused, remembering or finishing tasks.	1	2	3	4
❑	Problems sitting still, being too active, talking too much, or acting without thinking.	1	2	3	4
❑	Behavioral problems (does not follow rules, acts defiant, aggressive or has melt downs).	1	2	3	4
❑	Emotional problems (is often unhappy, depressed, nervous, worried, irritable or angry).	1	2	3	4
❑	Problems making or keeping friends.	1	2	3	4
❑	Difficulty with speaking or communicating, or with understanding the speech and communication of others.	1	2	3	4
❑	Odd behaviors, body movements, and/or focusing on only certain topics or interests.	1	2	3	4
❑	Daily living skills (dressing, eating, toileting, etc)	1	2	3	4
❑	Mental abilities (thinking, understanding and/or solving problems) seem low for their age.	1	2	3	4
❑	Unusual sensitivity to noises, sensations, tastes, and/or smells that interferes with daily living.	1	2	3	4
❑	Medication concerns (i.e. Is there a medication that might help my child? Can my child's existing medication be changed or adjusted to work better?)	1	2	3	4

Please tell us more about your concerns (attach a separate sheet if needed):_____

_____

_____

_____

What are your child's strengths and interests? _____

_____

_____

_____

What do you hope to achieve during this visit?_____

_____

Has your child ever been diagnosed with a problem with his/her development, behavior, emotions or learning? ❑Yes ❑ No
If yes, describe: _____

_____

Do you have another child who has been seen at this clinic? ❑ yes ❑ no By whom: _____

Do you believe your child is at risk of harming himself/herself or others? ❑ yes ❑ no Explain: _____

_____

_____

III. CURRENT FUNCTIONING Please tell us more about your child's abilities in the following areas:

Sleeping skills (Does your child go to sleep on his/her own at bedtime? Does s/he stay asleep through the night?)

Executive skills (Can your child finish tasks such as homework or chores independently? Does s/he follow directions?)

Managing Emotions (How does your child deal with normal emotions such as frustration, anxiety, or sadness? Does s/he get too emotional compared to other children?)

Nutrition (Does your child eat a variety of foods?)

Social skills (Does your child get along and start interactions with other children/adults?)

Play skills (How does your child play? Show imaginary or dramatic play? Play board/card games?)

Adaptive skills (How well can your child take care of him/herself for their age, i.e. dressing, toileting, personal hygiene)?

Reading skills (Can your child identify letters? Read familiar/new words? Read/understand sentences?)

Writing skills (Can your child write letters? Words? Sentences? A paragraph?)

Math skills (Can your child identify numbers? Count? Add and/or Subtract? Multiple and/or divide?)

Language (Does your child understand single words, sentences, or stories? Does your child usually speak in single words or full sentences? Can s/he tell a story?)

Gross motor skills (How well can your child sit, stand, walk, and run? Is s/he clumsy?)

Fine motor skills (Does your child have difficulty with buttons? Zippers? Writing? Tying shoes?)

IV. MEDICAL INFORMATION Is this child adopted? ❑ yes ❑ no At age_____from (country)_____

A. Pregnancy, Labor and Delivery History

How many times has mother been pregnant? _____ How many children does mother have? _____

Birth order of this child? _____ Age of mother when this child was born? __

Was mother healthy during the pregnancy of this child? ❑ yes ❑ no Explain:_____

Were there medical or other problems during the pregnancy or delivery (❑ fertility treatment ❑ infections (including herpes) ❑ unusual exposures)? Explain:

(Pregnancy, Labor and Delivery, cont.)

Did mother have any of the following tests: ❑ ultrasounds ❑ amniocentesis ❑ CVS ❑ Other: _____

Were any of them abnormal? Explain: _____

Did mother take/use any of the following during pregnancy?

- ❑ prescription medications:_____
- ❑ herbal remedies: _____
- ❑ over the counter medications: _____
- ❑ drank alcohol (e.g. wine, beer),_____# drinks per day
- ❑ smoked cigarettes,_____# packs per day
- ❑ drugs taken (e.g. marijuana, cocaine): _____

B. Birth History

Baby was born at_____ weeks Birth weight?_____lbs._____oz. Twin or triplet? ❑ yes ❑ no

Mode of delivery: ❑ Vaginal ❑ Cesarean Section Were there problems? ❑ yes ❑ no If yes, describe:_____

_____

Did your child go to the special care nursery or NICU? ❑ yes ❑ no If yes, # of days:_____Why? _____

_____

Did your child have any problems in the first few days of life? ❑ yes ❑ no If yes, describe:_____

_____

Did your child have feeding problems as a newborn or infant? ❑ yes ❑ no If yes, describe:_____

_____

C. Medical History (Review of Systems)

Are the child's immunizations up to date? ❑ yes ❑ no

Please indicate if your child has ever had any of the following:		
❑ Problems with vision	❑ Unusual reaction to immunization	❑ Heart problems
❑ Problems with hearing	❑ Seizures, convulsions or staring spells	❑ Too fast heart beat or chest pain
❑ Serious infections/illness	❑ Head injury/lost consciousness	❑ Problems with vomiting, diarrhea or constipation
❑ Serious injury/burn/broken bones	❑ Frequent headaches/migraines	❑ Frequent stomachaches
❑ Poisoning or exposure to toxic chemicals (e.g. lead)	❑ Fainting spells/dizziness	❑ Problems with kidney, bladder or urine
❑ Hospitalizations or surgeries?	❑ Problems with restless sleep or snoring	❑ Blood problems or anemia
❑ Frequent accidents/injuries	❑ Serious nose, mouth or throat problems	❑ History or suspicion of physical or sexual abuse
❑ Serious/chronic health problem (e.g. diabetes)	❑ Serious ear infections or ear tubes	❑ History or suspicion of tobacco, alcohol or drug use
❑ Over eats or overweight	❑ Motor tics (blinking, squinting, head tossing)	❑ If female, has gotten her period
❑ Small for age or underweight	❑ Vocal tics (grunting, throat clearing)	❑ Thyroid or hormone problems
❑ Difficulties with eating, diet, or appetite	❑ Breathing or lung problems	❑ Problems with gait (the way s/he walks)
❑ Birth defect or birth marks	❑ Compulsive behaviors	❑ Mental health problems

Does your child have any allergies? ❑ yes ❑ no If yes, list:_____

D. Medication History

Does your child take:	**Current or past?**	**Which ones and why?**
Prescription medications? ❑ yes ❑ no Prescribed by:		
Over the counter medications (including vitamins)? ❑ yes ❑ no		
Other biomedical/complementary/ alternative treatments? ❑ yes ❑ no		

V. FAMILY AND SOCIAL HISTORY

Who does the child live with most of the time? ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Adoptive Mother ❑ Adoptive Father ❑ Grandmother ❑ Grandfather ❑ Aunt ❑ Uncle ❑ Foster parent ❑ Group Home ❑ Brother(s) ❑ Sister(s) ❑ Cousin(s) ❑ Other: _____

Parents' marital status: ❑ Married ❑ Never married ❑ Separated / Divorced ❑ Widowed

Parent 1 Name: _____ Relationship to child: _____

Occupation: _____ Highest level of school completed: _____

Parent 2 Name: _____ Relationship to child: _____

Occupation: _____ Highest level of school completed: _____

Child's siblings or other children IN the home:	Full, half, adoptive, step, etc.	Age

Child's siblings NOT living in the home	Full, half, adoptive, step, etc.	Age

Are there any special circumstances in the family situation? (Attach separate sheet if necessary) _____

Has the child had a very upsetting experience? (e.g. witnessed violence, physical or sexual abuse) ❑ yes ❑ no If so, explain: _____

Has the child ever lived in an out-of-home placement? (e.g. foster care, residential center) ❑ yes ❑ no If so, explain:

Are there family problems that may be bothering the child? (e.g. serious illness, family members with mental health problems, divorce, financial problems, housing problems) ❑ yes ❑ no If so, explain: _____

Are there frequent arguments and/or physical abuse in the home? ❑ yes ❑ no If so, explain: _____

Does anyone in your immediate or extended family have/or had any of the following problems? (specify who)	
☐ Attention problems/ADHD:	☐ Heart problems before 50:
☐ Behavior problems:	☐ Physical or sexual abuse:
☐ Speech/language problems:	☐ Depression:
☐ School problems:	☐ Bipolar/ Manic Depression:
☐ Reading problems/dyslexia:	☐ Social problems/shyness:
☐ Seizures/neurological problems:	☐ Anxiety/Panic attacks:
☐ Mental Retardation/Intellectual Disability:	☐ Obsessive-Compulsive Disorders:
☐ Genetic Disorder/birth defect:	☐ Schizophrenia:
☐ Tics/Tourette's Syndrome:	☐ Alcohol problems:
☐ Autism Spectrum Disorder:	☐ Drug problems:
☐ Thyroid problems:	☐ Trouble with the law:

VI. DEVELOPMENTAL HISTORY

At what age did you become concerned with your child's development? _ _ Why? _____

Has your child ever lost skills? ❑ yes ❑ no If yes, when and what skills: _____

Please give us information on the following milestones:

When did your child begin to:	Age:	Not yet	When did your child begin to:	Age:	Not yet
Sit independently		❑	Stay dry during the day (toileting)		❑
Crawl independently		❑	Stay dry at night (toileting)		❑
Walk independently		❑	Dress/undress self		❑
Wave "bye bye"		❑	Feed self		❑
Point/show objects to others		❑	Write name, letters, colors		❑
Pretend/imaginary play		❑	Show interest in counting		❑
Speak in two word sentences		❑	Throw/ catch a ball		❑
Be understood by strangers		❑	Read simple words		❑

VII. SOCIAL, EMOTIONAL & BEHAVIORAL HISTORY

Please describe your child's personality:_____

_____

Please indicate if any of the following is TRUE of your child:	
❑ Does not make good eye contact when talking to you	❑ Doesn't try to use words to communicate
❑ Doesn't use gestures to communicate (i.e. pointing)	❑ Prefers to be alone; ignores others
❑ Echoes words or phrases	❑ Difficulty relating to peers or making friends
❑ Speaks in an unusual tone or manner	❑ Has unusual play behaviors; little pretend play
❑ It is hard to get child's attention	❑ Has unusual or very intense interests
❑ Seems preoccupied, aloof or distant	❑ Takes things literally; misses the point
❑ Has repetitive movements (examples: flaps hands, twists fingers, paces back and forth)	❑ Handles change poorly; insists on sameness

Do you have concerns about your child's behavior at: ❑home ❑ school ❑ in the community? If so, explain:

_____

_____

_____

Please indicate how often your child exhibits the following:	Never	Some-times	Often	Very Often
1. Makes many careless errors and doesn't pay attention to details				
2. Has difficulty concentrating on difficult tasks				
3. Does not seem to listen when spoken to directly				
4. Doesn't finish tasks (such as schoolwork); shifts from one activity to another				
5. Has difficulty organizing tasks, belongings or activities				
6. Avoids and dislikes tasks that require concentration or effort				
7. Loses or misplaces things				
8. Is easily distracted by noises or other things				
9. Is forgetful in daily activities				
10. Fidgets with hands; squirms in seat				
11. Has difficulty remaining seated when asked				
12. Runs or climbs when told not to				
13. Has difficulty playing quietly				
14. Is "on the go"; Acts like "driven by a motor"				
15. Talks too much				
16. Blurts out or answers questions before they have been completed, talks before thinking				

Please indicate how often you child does the following:	Never	Some-times	Often	Very Often
17. Has difficulty awaiting turn				
18. Interrupts (butts into conversations or games)				
19. Lose his/her temper				
20. Argues with adults				
21. Defies or refuses to do as asked				
22. Deliberately annoys others				
23. Blames others for own misbehavior or mistakes				
24. Is touchy or easily annoyed by others				
25. Is angry or resentful				
26. Tries to get even or takes out anger on others				
27. Is aggressive to people and/or animals (e.g. bullies/threatens others; starts fights; has used a weapon; physically cruel to people/animals; has robbed/mugged someone; forced someone into sex)				
28. Has deliberately destroyed property of others				
29. Does serious lying, cheating, and/or stealing things of value				
30. Stays out all night without permission, runs away or skips school				
31. Loss of interest or pleasure in everyday activities				
32. Changes in appetite or weight				
33. Difficulty with sleep (e.g. staying asleep, falling back asleep, sleeps too much)				
34. Feels useless or not as good as others (e.g. low self-esteem, blames self for problems)				
35. Is sad, unhappy or irritable (e.g. over-reacts, is easily upset, cries a lot)				
36. Low energy, tired, or fatigued				
37. Difficulty thinking, concentrating or making decisions				
38. Is fearful, anxious or worried				
39. Is restless or on edge				
40. Complains about body aches/muscle tension				
41. Can't stop worrying (germs, doing things perfectly, family in danger)				
42. Is afraid to try new things for fear of making mistakes or being embarrassed				
43. Has violent outbursts or tantrums including crying or clinging to others				
44. Worries about leaving home or being away from parents				
(OFFICE USE ONLY) 1-9: **/** 9 (IA: ≥ 6 / 9) 10-18: /9 (HI: ≥ 6/9) 19-26**:** /8 (ODD: ≥4/8) 27-30 (CD) 31-37 (MDD) 35-44 (AD)				

VII. PRESCHOOL/SCHOOL HISTORY

Current grade: _____ Type of classroom: ❑ Regular ❑ Integrated ❑ Substantially Separate On an IEP? ❑ yes ❑ no

How satisfied are you with your child's current school placement? ❑ Very Satisfied ❑ Somewhat Satisfied ❑ Not Satisfied

Please tell us more about the services your child receives or has received at SCHOOL:	
❑ 504 Plan (Accommodations), At age:	❑ Applied Behavioral Analysis (ABA) (❑ current ❑past)
❑ IEP (Special Education), At age:	❑ Counseling at school (❑ current ❑past)
❑ School testing (CORE Evaluation), when?	❑ Failed a grade/class, which one?
❑ Physical therapy (❑ current ❑past)	❑ Been suspended or expelled, when?
❑ Speech therapy (❑ current ❑past)	❑ Repeated a grade, which one?
❑ Occupational therapy (❑ current ❑past)	❑ Other:

IX. PREVIOUS EVALUATION AND OTHER SERVICE HISTORY

Private Evaluations (including psychiatrist, neurologist, developmental-behavioral pediatrician, or other professional)

Test done	With whom	Where	When

Medical Tests (including EEG, MRI, Genetics/Chromosome test, etc.)

Test done	With whom	Where	When

Please indicate any services your child receives or has received in the past OUTSIDE OF SCHOOL:

Service Type	Dates of Service	Service Provider (Name/#)
❑ Early Intervention, Why?		
❑ Social Worker / Case Manager		
❑ Speech and Language Therapy		
❑ Occupational Therapy		
❑ Physical Therapy		
❑ Tutoring		
❑ Applied Behavioral Analysis (ABA) Therapy		
❑ Mental Health Counseling (e.g. CBHI/in-home therapy, individual or family therapy)		
❑ Psychiatric or Drug Treatment Hospitalization		
❑ Department of Developmental Services (DDS)		
❑ Department of Mental Health (DMH)		
❑ Department of Children and Families (DCF)		
❑ Other:		

Is there anything else you would like to share with us? _____

_____

_____

_____

_____

_____

_____

_____

Dear Parent, thank you for completing this questionnaire. We would like to recommend that you:

- Keep a copy for your records (this is very important in case paperwork gets misplaced)
- If applicable, include your child's current IEP and any prior evaluations (school, medical, & private evaluations)
- IMPORTANT: If you have legal guardianship for this child, please include a copy of the legal documentation
- Send all forms and documentation to the Developmental & Behavioral Pediatrics office at the contact information listed on the first page.

We look forward to working with you and your child.