Silver Child Development Center
New Patient Questionnaire

Today's Date _____

Mother's Name _____ Date of Birth _____
First Last

Relation (circle) Biological Mother Stepmother Adoptive Mother Foster Mother Other_____

Father's Name _____ Date of Birth _____
First Last

Relation (circle) Biological Father Stepfather Adoptive Father Foster Father Other_____

Address _____

Do both parents live at this address? Yes____ No____
If no, please complete the secondary address line below

Address _____

This address is the Father's_____ Mother's_____

Child's Name _____ Date of Birth _____
First Middle Last

Gender Male _____ Female _____ Other _____

School History

Current School _____ Grade _____

Please circle all of the words below that describe your child's school program

E.H. Class	E.M.H. Class	T.M.H. Class	S.L.D. Class
Gifted Program	Speech	Vocational	Homebound
Private School	E.E.L.P.	Resource Room	Early Learning Center

According to the teacher, the child's schoolwork is…

_____ Below grade level _____ On grade level _____ Above grade level

Has the child repeated a grade?

_____ No _____ Yes; what grade? _____

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Reason for Referral

Why is the child being seen at the clinic? Please list the problems.

When did you first begin to notice these problems? What made you think something might be wrong?

What ways have you tried to solve the problem?

Have these ways worked?

How have the problems affected the family/household?

Are other people also concerned about the child? Who?

What do you think might be causing the child's problems?

Has the child ever been tested or treated for these problems? If so, please fill in the blanks below.

Dates seen	Reason seen	Seen by	Results

Family Information

Who lives with the child?

Name _____ Relation _____

Age _____ Problems? _____

Name _____ Relation _____

Age _____ Problems? _____

Name _____ Relation _____

Age _____ Problems? _____

Name _____ Relation _____

Age _____ Problems? _____

Does anyone else in the family (immediate or extended) have problems similar to the patient?

_____

_____

_____

_____

Current Medications (prescribed and over-the-counter, including herbs and supplements)

Medication	Dosage	How often	Do you frequently miss doses?

Pharmacy information: If we prescribe medication for your child, what pharmacy do you use:
Name:_____ Phone number: _____

Please list below any medications that your child has in the past:

Medication Daily Dose Purpose

a _____
b _____
c _____
d _____
e _____
f _____
g _____
h _____

Does your child have any drug allergies? Yes_____ No_____
If yes, what medication? _____

Mother's Pregnancy History

When the mother was pregnant with the child was she under the care of a doctor?
_____ Yes _____ No

How far along in the pregnancy was the mother when she started seeing a doctor?
_____ Months

During this pregnancy did the mother have any problems? Check all that apply:

_____ Toxemia/Eclampsia
_____ Bleeding; when? _____
_____ Frequent vomiting
_____ Serious injury
_____ Emotional distress
_____ Threatened miscarriages or early contractions
_____ Use of cigarettes
_____ Use of alcohol
_____ Sexually transmitted diseases
_____ Medication during pregnancy (not counting vitamins and iron)

Please List: _____

_____ Please list any other problems during the pregnancy: _____

_____

Birth History

Was the child born on time? _____ Yes _____ No; how early _____ Weeks

Delivery was: _____ Head first _____ Feet first _____ C-section

Did the baby have any problems during labor (i.e., drop in heart rate, failure to progress, cord around neck)?
_____ No _____ Yes; please list: _____

Did the baby have any problems after the delivery (i.e., need oxygen, jaundice)?
_____ No _____ Yes; please list: _____

Did the baby go into the NICU? _____ No _____ Yes; for how long? _____

Did the baby have any feeding problems? _____ Yes _____ No

Developmental History

For the following milestones please check the appropriate description (early, on time, late):

Milestones	Early or On Time	Late	If Late, approx. age
Gross Motor: Smiling, rolling over, sitting up without help, crawling and walking	____	____	____
Fine Motor: grasping objects, use of objects (utensils), operating buttons or zippers	____	____	____
Speech: saying first word, using 2 or 3 word sentences	____	____	____
Fully bowel trained	____	____	____
Dry and not wetting the bed	____	____	____

When the child was a baby, did he/she hold out arms and want to be picked up?

_____ No _____ Yes

When the child was a baby, did he/she like attention?

_____ No _____ Yes

When the child was a baby, did he/she want to be left alone?

_____ No _____ Yes

When the child was a baby, was he/she more interested in things than in people?

_____ No _____ Yes

Does the child have any sensory sensitivities? If so, please check all that apply.

_____ Sight _____ Sound _____ Texture _____ Touch

Children's Health Summary

Has your child had any of these health conditions (check all that apply)?

Diseases	Yes	Diseases	Yes
Asthma		Recurrent upper respiratory infections	
Autoimmune		Recurrent strep infections	
Concussion or Head injury		Recurrent ear infections	
Diabetes		Tubes surgically placed in ears	
Encephalitis or Meningitis			
Genetic disorders		Seizures	
Glaucoma		Sexually transmitted disease	
High cholesterol/lipids		Skin problems	
High Fever (105 or higher)		Thyroid disease	
Kidney disease		Tuberculosis (TB)	
Liver disease		HIV/AIDS	
Other (please list):			

List hospitalizations and surgeries:

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Does the child have any physical limitations? Yes_____ No_____

If yes, please explain: _____

Has the child ever had an EKG? Yes_____ No_____

If yes, when and what were the results: _____

Past labs? Yes_____ No_____

If yes, when and what were the results: _____

Personal and Family History:

Any history of:	Patient	Family	Relationship to patient
Chest pain or shortness of breath with exercise?			
High blood pressure?			
History of fainting or dizziness?			
History of heart murmur (other than an "innocent murmur")?			
Palpitations, increased heart rate, or extra skipped beats?			
Unexplained or noticeable change in exercise tolerance?			
"Heart Attack" in a family member <35 years of age?			
Sudden or unexplained death in someone young? Death during exercise?			
Cardiomyopathy? Arrhythmia? Wolfe Parkinson White syndrome? Short QT syndrome?			
Event requiring resuscitation in young family member including syncope or resuscitation?			
Marfan's syndrome?			
Rheumatic fever?			

1. Has there been any change in the child's general health within the last year? Yes_____ No_____
   If yes, please describe: _____

2. Who is the child's primary care provider? _____

   If you have not had a physical in the last year and do not have a primary care physician, please call USF Family Medicine at (813) 974-2918 or USF Pediatrics at (813) 974-8700.

3. When was the last physical examination? _____

4. What doctors or other healthcare providers is the child seeing currently? Please list:

Doctor/Therapist	Condition being treated	Since when/onset date

For Children age 10 and older, please answer questions 6-9:

5. Any signs of puberty? Yes_____ No_____ If so, which ones?_____

6. Is the youth currently using alcoholic beverages? Yes_____ No_____
   If yes, specify amount per day _____

7. Does the youth use tobacco? Yes_____ No_____
   If yes, what form, how much and how often? _____

8. Is the youth currently using any "recreational drugs" or taking prescription medications not prescribed for them? Yes_____ No_____
   If yes, which one(s), how often, and how much? _____

For female patients, please answer questions 9-12:

9. Age of onset of menstrual periods?_____

10. Date of last menstrual period?_____

11. Are menstrual periods regular? Yes_____ No_____

12. Is your child pregnant? Yes_____ No_____

Current Symptoms

Section A: Inattention and Hyperactivity

A1. In the **past 6 MONTHS** has your child:

		(Circle the number that best applies)			
		No	Sometimes	Often	Always
a	Failed to pay attention to details or made careless mistakes in schoolwork, work, or other activities?	0	1	2	3
b	Had difficulty paying attention when playing or doing some work?	0	1	2	3
c	Seemed not to listen when spoken to directly?	0	1	2	3
d	Not followed instructions, or failed to finish schoolwork or chores (even though he/she understood the instructions and weren't trying to be difficult)?	0	1	2	3
e	Had difficulty getting organized?	0	1	2	3
f	Avoided or disliked things that require a lot of thinking (like schoolwork or homework)?	0	1	2	3
g	Lost things he/she needed?	0	1	2	3
h	Become easily distracted by little things?	0	1	2	3
i	Become forgetful in his/her day-to-day activities?	0	1	2	3

A2. In the past 6 MONTHS has your child:

		(Circle the number that best applies)			
		No	Sometimes	Often	Always
a	Squirmed in his/her seat or fidgeted with his/her hands or feet?	0	1	2	3
b	Left your seat in class when he/she were not supposed to?	0	1	2	3
c	Run around and climbed a lot when he/she shouldn't or others didn't want him/her to?	0	1	2	3
d	Had difficulty playing quietly?	0	1	2	3
e	Felt like he/she was "driven by a motor" or was always "on the go"?	0	1	2	3
f	Talked too much?	0	1	2	3
g	Blurted out an answer before the question was completed?	0	1	2	3
h	Had difficulty waiting his/her turn?	0	1	2	3
i	Interrupted or intruded on others?	0	1	2	3

If you've answered NO to all in questions A1 and A2 THEN SKIP to SECTION B

A3. Has this disturbance in attention or activity level caused significant problems at:

	(Circle the number that best applies)			
	No	Sometimes	Often	Always
Home	0	1	2	3
School	0	1	2	3
With friends	0	1	2	3

A4. How old was your child when he/she first began having problems of attention and hyperactivity? _____

A5. Do you know of any family members that may have also had problems with attention and hyperactivity?

_____ No _____ Yes; who? _____

Section B: Motor and Vocal Tics

A "Tic" is a sudden, rapid, recurrent movement or vocalization which is difficult to resist or stop

B1. In the **past YEAR**, has your child experienced motor "tics" such as eye blinking, facial movements, neck jerking, shoulder shrugging, arm or head movements?

_____ No _____ Yes

B2. In the past YEAR, has your child experienced vocal "tics" such as throat clearing, grunting, sniffing, snorting, barking, repeating words or phrases?

_____ No _____ Yes

If you've answered NO to all in B1 and B2 THEN skip to SECTION C

B3. Has this disturbance caused significant problems at:

	(Circle the number that best applies)			
	No	Sometimes	Often	Always
Home	0	1	2	3
School	0	1	2	3
With friends	0	1	2	3

B4. Was your child taking any drugs or medicines just before these symptoms began?

_____ No _____ Yes; please list: _____

B5. How old was your child when he/she first began having tics? _____

B6. Do you know of any family members that may have also had tics at some time during their life?

_____ No _____ Yes; who? _____

Section C: Obsession and Compulsions

OBSESSIONS are reoccurring THOUGHTS, WORRIES, or IMAGES that are unwanted, distasteful, inappropriate, or intrusive, but which are difficult to stop (DO NOT include NORMAL worries about real life problems).

C1. In the **past MONTH**, has your child been bothered by any of the following obsessions?

		(Circle the number that best applies)			
		No	Sometimes	Often	Always
a	Fear of harming his/her self or someone else?	0	1	2	3
b	Fear that something bad will happen to someone?	0	1	2	3
c	Fear of losing things?	0	1	2	3
d	Forbidden sexual ideas or impulses?	0	1	2	3
e	Excessive need to save things others normally throw away?	0	1	2	3
f	Excessive concern or right/wrong or morality?	0	1	2	3
g	Excessive need for things to be "just right" or "perfect"?	0	1	2	3
h	Excessive need to know or remember?	0	1	2	3
i	Excessive concern for germs or dirt?	0	1	2	3

COMPULSIONS are reoccurring BEHAVIORS which are unwanted, distasteful, or inappropriate, but which are difficult to stop

C2. In the **past MONTH**, has your child been bothered by any of the following Compulsions?

		(Circle the number that best applies)			
		No	Sometimes	Often	Always
a	Excessive checking of things?	0	1	2	3
b	Excessive checking for mistakes?	0	1	2	3
c	Excessive re-reading or re-writing?	0	1	2	3
d	Need to repeat routine activities (e.g., in/out door, up/down stairs)?	0	1	2	3
e	Having to count or touch things a certain number of times?	0	1	2	3
f	Having to rearrange things over and over again?	0	1	2	3
g	Excessive list making?	0	1	2	3
h	Excessive cleaning or washing?	0	1	2	3

If you've answered NO to all in questions C1 and C2 THEN SKIP to SECTION D

C3. Has this disturbance caused significant problems at:

	(Circle the number that best applies)			
	No	Sometimes	Often	Always
Home	0	1	2	3
School	0	1	2	3
With friends	0	1	2	3

C4. Was your child taking any drugs or medicines just before these symptoms began?

_____ No _____ Yes; please list: _____

C5. How old was your child when he/she first began having obsessions and compulsions? _____

C6. Do you know of any family members that may have also had obsessions and compulsions?

_____ No _____ Yes; who? _____

Section D: Oppositional Defiant Syndrome

D1. In the **PAST 6 MONTHS** has your child displayed the following behaviors in a way that you and/or significant others believe was inappropriate for his/her age:

		(Circle the number that best applies)			
		No	Sometimes	Often	Always
a	Had temper tantrums?	0	1	2	3
b	Got into arguments with adults?	0	1	2	3
c	Actively defied or refused to comply with adults' requests?	0	1	2	3
d	Deliberately annoyed people?	0	1	2	3
e	Blamed others for his/her mistakes or misbehaviors?	0	1	2	3
f	Is touchy or easily annoyed by others?	0	1	2	3
g	Is angry or resentful toward others?	0	1	2	3
h	Is spiteful or vindictive?	0	1	2	3

If you've answered NO to all in questions D1, THEN SKIP to SECTION E

D2. Has this disturbance caused significant problems at:

	(Circle the number that best applies)			
	No	Sometimes	Often	Always
Home	0	1	2	3
School	0	1	2	3
With friends	0	1	2	3

Section E: Conduct Problems

E1. In the **past 12 MONTHS** has your child:

a	Bullied, threatened, or intimidated others?	NO	YES
b	Started fights?	NO	YES
c	Used a weapon that could harm someone (e.g., knife)	NO	YES
d	Deliberately hurt people	NO	YES
e	Deliberately hurt animals	NO	YES
f	Stolen things using force (e.g., armed robbery)	NO	YES
g	Forced anyone to have sex with him/her	NO	YES
h	Deliberately started fires to damage property	NO	YES
i	Deliberately destroyed things belonging to others	NO	YES
j	Broken into someone's house or car	NO	YES
k	Lied repeatedly to get things or tricked other people	NO	YES
l	Stolen things	NO	YES
m	Stayed out late at night in spite of you forbidding him/her,	NO	YES
n	Run away from home at least twice	NO	YES
o	Often skipped school	NO	YES

E3. Does your child's history include:

Physical or sexual abuse?	NO	YES
Traumatic divorce?	NO	YES
Other stresses? _____	NO	YES

Does the child or family have specific religious or cultural practices that may affect your treatment?

If so, please describe: _____

Review of Systems (Child and Adolescent)

In each area, if you are not having difficulties, please circle "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask your doctor.

Const. (Health in general): no problems | lack of energy | unexplained weight gain or weight loss | loss of appetite | fever | night sweats | pain in jaws when eating | scalp tenderness | prior diagnosis of cancer | other:_____

Eyes: no problems | vision changes | wearing glasses | dry eyes | watery eyes | other:_____

Ears, Nose, Mouth, & Throat: no problems | difficulty with hearing | sinus problems | runny nose | post-nasal drip | ringing in ears | mouth sores | loose teeth | ear pain | nosebleeds | sore throat | facial pain or numbness | other:_____

C-V (Heart & Blood Vessels: no problems | irregular heartbeat | racing heart | chest pains | swelling of feet or legs | pain in legs with walking | other:_____

Resp. (Lungs & Breathing): no problems | shortness of breath | night sweats | prolonged cough | wheezing | sputum disorder | prior tuberculosis | coughing up blood | abnormal chest x-ray | snoring or leg pain at night | other:_____

GI (Stomach & Intestines): no problems | heartburn | constipation | intolerance to certain foods | diarrhea | abdominal pain | difficulty swallowing | nausea | vomiting | blood in stools | unexplained change in bowel habits | incontinence | other:_____

GU (Kidney & Bladder): no problems | painful urination | frequent urination | urgency | bladder problems | sexually transmitted diseases | other:_____

MS (Muscles, Bones, Joints): no problems | joint pain | aching muscles | shoulder pain | swelling of joints | joint deformities | back pain | other:_____

Integ. (Skin, Hair, & Breast): no problems | persistent rash | itching | new skin lesion | change in existing skin lesion | hair loss or increase | breast changes | other:_____

Neurologic (Brain & Nerves): no problems | frequent headaches | double vision |weakness | change in sensation | problems with walking or balance | dizziness | tremor | loss of consciousness | uncontrolled motions | episodes of visual loss | other:_____

Endocrinologic Glands): no problems | intolerance to heat or cold | menstrual irregularities | frequent hunger/urination/thirst | changes in sex drive | other:_____

Hematologic (Blood/Lymph): no problems | easy bleeding | easy bruising | anemia | abnormal blood tests | leukemia | unexplained swollen areas | other:_____

Allergic/Immunologic: no problems | seasonal allergies | hay fever symptoms | itching | frequent infections | exposure to HIV | other:_____

For Staff Use Only

Reviewed by: _____

Date/Time: _____