

**VANDERBILT DIVISION OF DEVELOPMENTAL MEDICINE**

**PARENT QUESTIONNAIRE**

**Date:** \_\_\_\_\_

**Form completed by:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_

**Child's name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex** M F

**Race/Ethnicity** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(Street, P.O. Box, route, etc.)

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **County:** \_\_\_\_\_

Please list another phone number where you can be reached (friend, relative, neighbors etc.): \_\_\_\_\_

What are your concerns about your child?

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When did you first become concerned about your child's development?

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What would you like the Center for Child Development to do for you and your child?

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Has your child had any other testing or evaluation? If so, where? By whom? What were the results?

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What have you been told is your child's problem or diagnosis?

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List any services your child receives: (TEIS, speech-language therapy, physical/occupational therapy, developmental preschool, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CHILD'S BIRTH HISTORY:**

Baby's birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.  
 Was the birth: On time? \_\_\_\_\_ Weeks early? \_\_\_\_\_ Weeks late? \_\_\_\_\_ Mother's age at delivery? \_\_\_\_\_  
 How many pregnancies? \_\_\_\_\_ Miscarriages \_\_\_\_\_ Terminations \_\_\_\_\_ has mother had?  
 Health of birth mother during pregnancy: \_\_\_\_\_ excellent \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor  
 Did mother have any concerns during pregnancy? \_\_\_\_\_ YES \_\_\_\_\_ NO If yes, please specify:  
 \_\_\_\_\_  
 \_\_\_\_\_

**During the mother's pregnancy, did any of the following occur?**

		If yes, description or extent of use
Accident:	_____ Yes _____ No	_____
Illness/diseases/conditions:	_____ Yes _____ No	_____
Medications:	_____ Yes _____ No	_____
Use of tobacco:	_____ Yes _____ No	_____
Use of alcohol:	_____ Yes _____ No	_____
Use of drugs:	_____ Yes _____ No	_____
Exposure to infectious disease:	_____ Yes _____ No	_____

Did baby's movement in the womb seem normal?	YES	NO	
Father's age at delivery			
Was labor induced (brought on by shots or IV)?	YES	NO	
Was delivery	Head first?	Feet first?	By Caesarean?
Were there any complications?	YES	NO	Apgar scores if known:
Was baby in the intensive care unit?	YES	NO	If yes, how long?
Did the baby have birth defects?	YES	NO	If yes, describe below:
Did the baby have trouble sucking?	YES	NO	
Did the baby have trouble breathing?	YES	NO	
Did the baby have jaundice?	YES	NO	

**DEVELOPMENTAL HISTORY:**

Please list the ages at which your child:

Rolled over \_\_\_\_\_ Sat alone \_\_\_\_\_ Crawled \_\_\_\_\_ Pulled to stand \_\_\_\_\_  
 Walked \_\_\_\_\_ Spoke first words \_\_\_\_\_ Spoke first sentence \_\_\_\_\_ Fed with spoon \_\_\_\_\_  
 Fed with fork \_\_\_\_\_ Rode tricycle \_\_\_\_\_ Toilet trained: *day* \_\_\_\_\_ *night* \_\_\_\_\_

**HEALTH HISTORY** Has your child ever had? Please check one for each item.

Hospitalizations or other major illness?	YES	NO	
Surgery?	YES	NO	
Head trauma or loss of consciousness?	YES	NO	If yes, for how long?
Genetic testing?	YES	NO	
Brain imaging? (CT scan, MRI)	YES	NO	
Allergies to medication?	YES	NO	
Are immunizations up to date?	YES	NO	
Lost abilities that child once had?	YES	NO	If yes, list abilities lost.

Child's current Primary Care Physician: \_\_\_\_\_

His/her address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list other doctors your child sees on a regular basis: \_\_\_\_\_,  
 \_\_\_\_\_,  
 \_\_\_\_\_,

**Please list any medication taken by your child on a regular basis:**

<u>Name</u>	<u>Reason for Taking</u>	<u>Dosage (how much each day)</u>	<u>When started?</u>
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

Results of vision screen: \_\_\_\_\_ Passed \_\_\_\_\_ Failed      When was child screened? \_\_\_\_\_

Who completed the screen? \_\_\_\_\_

Results of hearing screen: \_\_\_\_\_ Passed \_\_\_\_\_ Failed      When was child screened? \_\_\_\_\_

Who completed the screen? \_\_\_\_\_

**FAMILY HISTORY: Please mark × if present in any biological family member, and then describe the nature of problem and in whom:**

___ Learning problems _____	___ Deafness _____
___ Special Education _____	___ Mental Illness _____
___ Intellectual Disability _____	___ Cerebral Palsy _____
___ Speech-Language _____	___ Muscular dystrophy _____
___ Autism _____	___ Birth defects _____
___ ADHD _____	___ Tics/Tourette's _____
___ Seizures _____	___ Genetic Conditions _____
___ Blindness _____	___ Parkinson's _____
___ Tremors _____	___ Arrhythmia _____
___ Other _____	___ Sudden death or heart attack under age 55 _____

**OTHER MEDICAL HISTORY: Please describe any concerns or problems with:**

Eyes/Vision \_\_\_\_\_

Ears/Nose/Throat \_\_\_\_\_

Heart Murmur or Cardiac Problems \_\_\_\_\_

Wheezing/Pneumonia \_\_\_\_\_

Growth \_\_\_\_\_

Eating/Chewing/Choking/Drooling \_\_\_\_\_

Vomiting/Diarrhea/Constipation \_\_\_\_\_

Bladder or Kidney Problems \_\_\_\_\_

Bones/Joints/Muscles \_\_\_\_\_

Seizures/Brain problems \_\_\_\_\_

Skin rashes/Birthmarks \_\_\_\_\_

Sleep Problems \_\_\_\_\_

**Please describe the child's family:**

Who lives with the child?

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Marital status of parents: \_\_\_\_\_

**Parent #1** \_\_\_\_\_ **Age** \_\_\_\_\_

**Educational Level:** \_\_\_\_\_ **currently working outside the home?** Yes No

**Occupation** \_\_\_\_\_

**Place of employment** \_\_\_\_\_

**Parent # 2** \_\_\_\_\_ **Age** \_\_\_\_\_

**Educational Level:** \_\_\_\_\_ **Currently working outside the home?** Yes No

**Occupation** \_\_\_\_\_

**Place of employment** \_\_\_\_\_

**If child lives with other guardian (please bring custody documentation):**

**Guardian's name:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_ **Educational Level:** \_\_\_\_\_

**Currently working outside the home?** Yes No **Occupation:** \_\_\_\_\_

**Please list other children living in the home:**

<b>Name</b>	<b>Sex</b>	<b>Age</b>	<b>Relationship to child</b>
_____			
_____			
_____			

Are there any family circumstances that have affected your child? **Please check all that apply:**

- |   |   |
|---|---|
| <input type="checkbox"/> Family moves                           | <input type="checkbox"/> Financial difficulties           |
| <input type="checkbox"/> Illness or disability of family member | <input type="checkbox"/> Death of family member or friend |
| <input type="checkbox"/> Marital problems                       | <input type="checkbox"/> Abuse                            |
| <input type="checkbox"/> Separation or divorce                  | <input type="checkbox"/> Custody or visitation issues     |
| <input type="checkbox"/> Step-family problems or issues         | <input type="checkbox"/> Drug or alcohol problems         |
| <input type="checkbox"/> Family violence                        | <input type="checkbox"/> Neighborhood violence            |
| <input type="checkbox"/> Other                                  |   |

**Additional comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please enclose a recent picture of your child, if available.**

Return this completed form in the self-addressed, stamped envelope provided. Thank you.

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