Child Study Center & Center on Child Abuse & Neglect
1100 NE 13th St. Oklahoma City, OK 73114
Phone: 405-271-5700 Fax: 405-271-2992

OU DEVELOPMENTAL BEHAVIORAL PEDIATRICS PATIENT QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

PATIENT NAME (last, first): _____

DATE OF BIRTH: _____ AGE: _____ GENDER: ☐M ☐F

NAME OF PERSON COMPLETING THIS FORM: _____

RELATIONSHIP TO CHILD: _____ TODAY'S DATE: _____

LANGUAGE PREFERENCE: _____ TRANSLATOR NEEDED? ☐ YES ☐ NO

CONCERNS

Please tell us, in your own words, what your main concerns are for your child and why you are seeking this appointment. (For example: Medication consult, ADHD evaluation and treatment, counseling, problem behaviors, anxiety, abuse, trauma, learning impairments, dyslexia, speech delays, etc.) **If learning problems:** please specify the social and emotional impact of impairments. **If Autism**: please specify symptoms (e.g. nightmares, not getting along with others, physically aggressive, developmental delay, etc.) **Please use a separate sheet if you need to write more than space allows. Please copy and attach any records of previous evaluations, hearing tests, school forms like "IEPs" or "504 plans."**

_____

_____

_____

_____

_____

_____

_____

PLEASE CHECK ALL SYMPTOMS OR BEHAVIORS THAT APPLY TO YOUR CHILD:

- ☐ ANXIOUS/SCARED
- ☐ CLINGY
- ☐ DEPRESSED
- ☐ CRIES OFTEN/VERY UPSETTABLE
- ☐ AGGRESSIVE
- ☐ ANGRY
- ☐ EXTREME TANTRUMS
- ☐ ARGUES
- ☐ NOT FOLLOWING DIRECTIONS
- ☐ LYING
- ☐ KICKED OUT OF DAYCARE/SCHOOL
- ☐ DOESN'T PLAY WELL WITH OTHER CHILDREN
- ☐ FLAPS HANDS
- ☐ LINES THINGS UP
- ☐ SPINS THINGS OR SELF
- ☐ SENSITIVE TO SOUNDS
- ☐ SENSITIVE TO TEXTURES
- ☐ HIGH PAIN TOLERANCE
- ☐ NOT TALKING WELL
- ☐ DOESN'T SEEM TO UNDERSTAND ME
- ☐ NOT PAYING ATTENTION
- ☐ HYPERACTIVE
- ☐ LEARNING DIFFICULTIES
- ☐ HEARING LOSS/CONCERNS
- ☐ PICKY EATER
- ☐ GROWTH CONCERNS
- ☐ TOILETING CONCERNS
- ☐ CONSTIPATION
- ☐ CHRONIC ILLNESS
- ☐ OTHER: (please describe) _____

_____

_____

_____

CHILD TRAUMA HISTORY

HAS THE CHILD EXPERIENCED A TRAUMATIC EVENT? ☐ YES (CONFIRMED) ☐ SUSPECTED ☐ NO IF "YES," PLEASE COMPLETE BELOW (**check all that apply**):

- ☐ PHYSICAL ABUSE
- ☐ SEXUAL ABUSE
- ☐ NEGLECT
- ☐ PSYCHOLOGICAL/EMOTIONAL ABUSE
- ☐ WEATHER DISASTER
- ☐ ACCIDENT
- ☐ WITNESSED INTIMATE PARTNER VIOLENCE (IPV) / DOMESTIC VIOLENCE (DV)
- ☐ COMMUNITY VIOLENCE
- ☐ MEDICAL PROCEDURE/ILLNESS
- ☐ SCHOOL VIOLENCE
- ☐ WAR/TERRORISM
- ☐ OTHER: _____

_____

_____

PLEASE EXPLAIN EACH CHECKED ITEM: _____

_____

_____

_____

_____

MEDICAL HISTORY

HOW WOULD YOU DESCRIBE YOUR CHILD'S OVERALL HEALTH? ☐ POOR ☐ FAIR ☐ GOOD ☐ VERY GOOD ☐ EXCELLENT

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? **(check all that apply)**:

☐ EYES CROSSING/LAZY EYE
☐ HEARING PROBLEMS
☐ FAINTING
☐ CAVITIES
☐ EAR TUBES
☐ HEART PROBLEM
☐ MAJOR SURGERY
☐ OVERNIGHT STAY IN HOSPITAL
☐ ASTHMA
☐ WEARS GLASSES
☐ CONSTIPATON
☐ SEASONAL ALLERGIES
☐ OTHER: _____
_____
_____
_____

PLEASE INDICATE IF YOUR CHILD OR YOUR CHILD'S BLOOD RELATIVE HAS EVER BEEN DIAGNOSED, EVALUATED, OR TREATED FOR THE FOLLOWING:

CHILD				BLOOD RELATIVE	
DIAGNOSED	EVALUATED	TREATED		DIAGNOSED	WHICH RELATIVE?
☐	☐	☐	AUTISM SPECTRUM DISORDER	☐	_____
☐	☐	☐	ASPERGERS DISORDER	☐	_____
☐	☐	☐	PERVASIVE DEVELOPMENTAL DISORDER (PDD)	☐	_____
☐	☐	☐	DEVELOPMENTAL DELAY	☐	_____
☐	☐	☐	INTELLECTUAL DISABILITY (formerly called mental retardation)	☐	_____
☐	☐	☐	EMOTIONALLY DISTURBED (a school diagnosis)	☐	_____
☐	☐	☐	ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)	☐	_____
☐	☐	☐	OPPOSITIONAL DEFIANT DISORDER (ODD)	☐	_____
☐	☐	☐	ANXIETY DISORDER/PANIC ATTACKS	☐	_____
☐	☐	☐	BIPOLAR DISORDER	☐	_____
☐	☐	☐	DEPRESSION	☐	_____
☐	☐	☐	SCHIZOPHRENIA	☐	_____
☐	☐	☐	ATTACHMENT DISORDER	☐	_____
☐	☐	☐	POST TRAUMATIC STRESS DISORDER (PTSD)	☐	_____
☐	☐	☐	OBSESSIVE-COMPULSIVE DISORDER (OCD)	☐	_____
☐	☐	☐	SEPARATION ANXIETY DISORDER	☐	_____
☐	☐	☐	GENETIC DISORDER	☐	_____
☐	☐	☐	SEIZURE DISORDER	☐	_____
☐	☐	☐	HEART DISEASE/SUDDEN DEATH AT YOUNG AGE	☐	_____
☐	☐	☐	LEARNING DISABILITY **(or need for special education, please specify)** _____	☐	_____
☐	☐	☐	OTHER **(please describe)** _____	☐	_____

MOST RECENT HEARING TEST: DATE _____ LOCATION _____ RESULTS _____

MOST RECENT VISION TEST: DATE _____ LOCATION _____ RESULTS _____

PLEASE LIST MEDICATIONS, HERBS, TREATMENTS, OR SPECIAL DIETS YOUR CHILD TAKES OR USES (**Please use a separate sheet if you need more space.**):

MEDICATIONS/HERBS/TREATMENTS/SPECIAL DIETS	DOSAGE	FREQUENCY	REASON

ANY ALLERGIES TO **MEDICATIONS?** ☐ YES ☐ NO ANY ALLERGIES TO **FOOD**? ☐ YES ☐ NO **IF "YES," PLEASE COMPLETE THE TABLE BELOW:**

MEDICATION/FOOD	DATE OF THE MOST RECENT REACTION	SYMPTOMS EXPERIENCED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY AND BIRTH HISTORY

WAS YOUR CHILD'S PREGNANCY EXPECTED? ☐ YES ☐ NO AGE OF MOTHER AT PREGNANCY: _____ # OF PRIOR PREGNANCIES: _____ # OF MISCARRIAGES _____

WERE THERE ANY FERTILITY PROBLEMS? ☐ YES ☐ NO NUMBER OF WEEKS PREGNANT WHEN PREGNANCY WAS RECOGNIZED: _____

DID THE CHILD'S MOTHER USE ALCOHOL, TOBACCO, OR DRUGS DURING PREGNANCY, INCLUDING BEFORE THE PREGNANCY WAS KNOWN? ☐ YES ☐ NO

IF "YES," PLEASE CHECK ALL THAT APPLY: ☐ ALCOHOL ☐ TOBACCO ☐ RECREATIONAL DRUGS (**please list**) ☐ PRESCRIPTION MEDICATIONS (**please list**)

_____

_____

_____

_____

_____

_____

COMPLICATIONS DURING PREGNANCY? ☐ YES ☐ NO IF "YES," PLEASE DESCRIBE: _____

_____

DID THE CHILD'S MOTHER NEED TO VISIT THE ER DURING PREGNANCY? ☐ YES ☐ NO IF "YES," PLEASE DESCRIBE: _____

_____

NUMBER OF WEEKS AT DELIVERY: _____ BIRTH WEIGHT: _____POUNDS _____OUNCES COMPLICATIONS OF DELIVERY: ☐ LONG LABOR ☐ INFECTION

☐ TROUBLE BREATHING/RESPIRATORY DISTRESS ☐ NICU ☐ OTHER: _____

DETAILS OF DELIVERY: ☐ NORMAL VAGINAL BIRTH ☐ FORCEPS ☐ VACUUM ASSIST ☐ CESAREAN SECTION (C-SECTION) ☐ BREECH BIRTH

DEVELOPMENTAL HISTORY

PLEASE INDICATE WHAT YOU FEEL YOUR CHILD'S DEVELOPMENT IS IN THE FOLLOWING AREAS (**please check all that apply**):

ADVANCED	AVERAGE	BEHIND	VERY BEHIND	
☐	☐	☐	☐	PHYSICAL DEVELOPMENT
☐	☐	☐	☐	MOTOR SKILL DEVELOPMENT
☐	☐	☐	☐	EMOTIONAL DEVELOPMENT
☐	☐	☐	☐	ACADEMIC DEVELOPMENT
☐	☐	☐	☐	LANGUAGE DEVELOPMENT
☐	☐	☐	☐	INTELLECTUAL AND THINKING SKILLS DEVELOPMENT
☐	☐	☐	☐	SOCIAL DEVELOPMENT
☐	☐	☐	☐	PROBLEM SOLVING SKILLS
☐	☐	☐	☐	FINE MOTOR SKILLS
☐	☐	☐	☐	DAILY LIVING SKILLS (like getting dressed or toileting)
☐	☐	☐	☐	RELATIONSHIP WITH SIBLINGS
☐	☐	☐	☐	RELATIONSHIP WITH PARENTS AND CAREGIVERS

AT WHAT AGE IN MONTHS DID YOUR CHILD: CRAWL _____ TAKE FIRST STEP _____ WALK _____ RUN _____

SPEAK 1ST WORD _____ SPEAK 2-WORD PHRASES: _____ SPEAK FULL SENTENCES: _____

HOW DOES YOUR CHILD COMMUNICATE? (**check all that apply**) ☐ GESTURES ☐ WORDS ☐ PHRASES ☐ SENTENCES ☐ OTHER: _____

_____

_____

WHAT DOES YOUR CHILD DO WITH A PENCIL? (**check all that apply**) ☐ SCRIBBLE ☐ COPY A CIRCLE ☐ COPY A SQUARE ☐ COPY A TRIANGLE ☐ DRAW A LINE

☐ DRAW A SIMPLE PERSON ☐ DRAW A PERSON WITH MANY BODY PARTS ☐ DRAW RECOGNIZABLE THINGS ☐ OTHER: _____

_____

_____

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EDUCATION

AGE AT WHICH YOU OR OTHERS BECAME CONCERNED ABOUT YOUR CHILD'S DEVELOPMENT: _____ DOES YOUR CHILD ATTEND SCHOOL? ☐ YES ☐ NO

WHAT GRADES DOES YOUR CHILD MAKE? (**disregard if child not in school**) ☐ A's ☐ B's ☐ C's ☐ D's ☐ F's EVER REPEATED A GRADE? ☐ YES ☐ NO

NAME OF PRESENT SCHOOL: _____ GRADE: _____

TEACHER'S NAME: _____ CITY: _____

DO YOU HAVE ANY CONCERNS REGARDING YOUR CHILD'S EDUCATIONAL PERFORMANCE? ☐ YES ☐ NO IF "YES," PLEASE DESCRIBE: _____

_____

_____

_____

PLEASE CHECK ANY SERVICES RELATED TO YOUR CHILD **(current or past)**

CURRENT	PAST	ON WAIT LIST	INTERESTED		DATE SERVICE BEGAN	DATE SERVICE ENDED
☐	☐	☐	☐	EARLY INTERVENTION/SOONER START	_____	_____
☐	☐	☐	☐	DEVELOPMENTAL DELAY PRESCHOOL	_____	_____
☐	☐	☐	☐	HEAD START	_____	_____
☐	☐	☐	☐	INDIVIDUALIZED EDUCATION PLAN (IEP)	_____	_____
☐	☐	☐	☐	PRE-K	_____	_____
☐	☐	☐	☐	SPEECH THERAPY	_____	_____
☐	☐	☐	☐	OCCUPATIONAL THERAPY	_____	_____
☐	☐	☐	☐	PHYSICAL THERAPY	_____	_____
☐	☐	☐	☐	SOCIAL SKILLS GROUP	_____	_____
☐	☐	☐	☐	COUNSELING	_____	_____
☐	☐	☐	☐	BEHAVIOR THERAPY	_____	_____
☐	☐	☐	☐	PARENTING CLASSES	_____	_____
☐	☐	☐	☐	OTHER: _____	_____	_____

PLEASE PROVIDE ANY RECORDS YOU HAVE OF THE ABOVE EVALUATIONS, SERVICE PLANS, AND DIAGNOSTIC TESTING

HOME AND FAMILY

PLEASE LIST ALL WHO LIVE WITH THE CHILD:

FULL TIME	PART TIME	NAME OF INDIVIDUAL	RELATIONSHIP TO CHILD
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____

HAS THE CHILD LIVED IN OTHER HOMES PRIOR TO HIS OR HER CURRENT HOME? ☐ YES ☐ NO

PLEASE INDICATE WHO PROVIDES SUPPORT TO THE PRIMARY CAREGIVER IN CARING FOR THIS CHILD (**check all that apply**):

☐ CHILD'S IMMEDIATE FAMILY
☐ CAREGIVER'S IMMEDIATE FAMILY (ex: grandparents)
☐ FRIENDS
☐ CHURCH
☐ SUPPORT GROUP
☐ PARENT/FAMILY NETWORKS
☐ SOCIAL SECURITY
☐ DISABILITY
☐ WELFARE
☐ UNEMPLOYMENT PAYMENTS
☐ CHILD SUPPORT PAYMENTS
☐ HOUSING ASSISTANCE
☐ ENERGY ASSISTANCE
☐ WIC/FOOD STAMPS
☐ FREE OR REDUCED SCHOOL MEALS
☐ TRIBAL AFFILIATION
☐ TRIBAL SUPPORT
☐ DAYCARE
☐ TANF
☐ PRIVATE INSURANCE
☐ SOONER CARE
☐ MEDICAID
☐ MORE SUPPORT IS NEEDED
☐ OTHER: _____
_____
_____
_____

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ADDITIONAL INFORMATION

WHAT IS THE BEST PART ABOUT RAISING THIS CHILD? _____

IS THERE ANYTHING ELSE THAT WE HAVEN'T COVERED? _____

Responsible Party Signature: _____ Date: _____

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PATIENT INFORMATION

PLEASE COMPLETE ALL INFORMATION THAT WAS NOT PREVIOUSLY PROVIDED OR THAT HAS CHANGED SINCE THE REFERRAL:

PATIENT NAME (first, last): _____

DATE OF BIRTH: _____ AGE: _____ GENDER: ☐M ☐F

TODAY'S DATE: _____ IS THE CHILD A NEW OR RETURNING PATIENT TO CSC/CCAN? ☐ NEW PATIENT ☐ RETURNING PATIENT

NAME OF PERSON COMPLETING THIS FORM: _____ RELATIONSHIP TO CHILD: _____

CAREGIVER(S)/PARENT(S) NAME(S): _____

CAREGIVER/PARENT TYPE: ☐BIOLOGICAL PARENT ☐GRANDPARENT ☐ADOPTIVE PARENT ☐STEP PARENT ☐FOSTER PARENT** ☐LEGAL GUARDIAN

☐OTHER: _____

PHONE #: PREFERRED (_____) _____ SECONDARY (_____) _____ EMAIL: _____

CAREGIVER'S/PATIENT'S ADDRESS: _____
STREET CITY STATE ZIP CODE

CAREGIVER'S OCCUPATION: _____

REFERRAL SOURCE: ☐ PRIMARY CARE PHYSICIAN: _____ ☐ FRIEND ☐ RELATIVE ☐ SELF

☐ OTHER: _____

LANGUAGE PREFERENCE: _____ TRANSLATOR NEEDED? ☐ YES ☐ NO

CHILD'S RACE: ☐ NON-HISPANIC ☐ HISPANIC ☐ AMERICAN INDIAN ☐ AFRICAN AMERICAN ☐ WHITE ☐ LATINO ☐ OTHER: _____

_____

IF A CANCELATION RESULTING IN AN AVAILABLE APPOINTMENT OCCURRED, WOULD YOU BE ABLE TO BRING IN YOUR CHILD ON SHORT NOTICE? ☐ YES ☐ NO

IF "YES," HOW MUCH OF A NOTICE DO YOU NEED? ☐ 1 HOUR ☐ 2 HOURS ☐ 4 HOURS ☐ THE MORNING BEFORE AN AFTERNOON APPOINTMENT

☐ THE DAY BEFORE THE APPOINTMENT ☐ OTHER: _____

WHAT NUMBER SHOULD WE CALL TO CONTACT YOU IN THIS SITUATION? ☐ PREFERRED ☐ SECONDARY ☐ OTHER: (_____) _____

****IS PATIENT IN DHS CUSTODY? ☐YES ☐NO IF "YES", DHS CASE WORKER NAME: _____**

CASE WORKER COUNTY: _____CASE WORKER CELL PHONE#: (_____)_____

CASE WORKER OFFICE PHONE #: (_____)_____CASE WORKER FAX #: (_____)_____

PRIMARY CARE PROVIDER INFORMATION

PRIMARY CARE PROVIDER: _____

PCP OFFICE ADDRESS: _____
STREET CITY STATE ZIP CODE

PCP PHONE #: (_____) _____ EXT: _____ PCP FAX #:(_____) _____

INSURANCE AND PAYMENT INFORMATION

ATTACH COPIES OF BOTH SIDES OF INSURANCE CARDS

NAME OF PRIMARY INSURANCE: _____

NAME OF POLICY HOLDER (PH): _____

PH DATE OF BIRTH: _____

PH RELATIONSHIP TO PATIENT: _____

PH SOCIAL SECURITY NUMBER: _____

PLAN/GROUP #: _____

ID #: _____

NAME OF SECONDARY INSURANCE: _____

NAME OF POLICY HOLDER (PH): _____

PH DATE OF BIRTH: _____

PH RELATIONSHIP TO PATIENT: _____

PH SOCIAL SECURITY NUMBER: _____

PLAN/GROUP #: _____

ID #: _____

NAME OF GUARANTOR (the person responsible for payment of services): _____

GUARANTOR RELATIONSHIP TO PATIENT: _____ GUARANTOR SOCIAL SECURITY NUMBER: _____

GUARANTOR DATE OF BIRTH: _____ ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

GUARANTOR PREFERRED PHONE #:_____ GUARANTOR SECONDARY PHONE #:_____

GUARANTOR EMAIL ADDRESS: _____

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