UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

CHILD DEVELOPMENT UNIT

CHILD AND FAMILY QUESTIONNAIRE

Patient Name

Medical Record Number

Birthdate

Please complete this form and return to the Child Development Unit:

Email: CHPChildDevelopment@upmc.edu ***Phone:*** 412-692-5560 ***Fax:*** 412-692-5679

Mailing Address: Attn: CDU, UPMC Children's Hospital of Pittsburgh, 4401 Penn Ave, Pittsburgh, PA 15224

Child's Name: _____ _____ _____
First MI Last

Preferred Name: _____ Age: _____

Date of Birth: _____ Sex: _____ Gender: _____

Person Completing Form: _____ Date Completed: _____

Does your family have any special needs regarding ability, language, culture, or religion? _____

_____

If an interpreter is needed, please specify which language: _____

Household Information:

Who has primary legal custody and medical decision-making abilities for the child?

☐ shared by both parents/both legal guardians ☐ other _____

Parent/Guardian/Primary Caregiver Name (1)

_____

Relationship to child *(check all that apply)*:

☐ mother ☐ father ☐ other_____

☐ biological ☐ adopted ☐ foster care

*If child is currently in foster care, please list names of biological parents/legal guardians here:*_____

_____

Occupation (1): _____

Check degrees held, if any: ☐ High School/GED

☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Street Address: _____

_____

City: _____ State: _____

County: _____. Zip: _____

Child's primary residence? ☐ Yes ☐ No

Phone: _____

Alternative phone: _____

Email: _____

Parent/Guardian/Other Caregiver Name (2)

_____

Relationship to child *(check all that apply)*:

☐ mother ☐ father ☐ other_____

☐ biological ☐ adopted ☐ foster care

☐

Occupation (2): _____

Check degrees held, if any: ☐ High School/GED

☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Street Address: ☐ Check here if same as **(1)**

_____

City: _____ State: _____

County: _____. Zip: _____

Child's primary residence? ☐ Yes ☐ No

Phone: _____

Alternative phone: _____

Email: _____

Household Information, continued:

Who lives in the primary household with the child? ☐ Parent/Guardian (1) ☐ Parent/Guardian (2)

☐ Sibling(s) or step-sibling(s) _____

_____

☐ Other _____

Parents or siblings living outside the primary household: _____

_____

Visit Information and Medical History:

What is your main question about your child? _____

_____

_____

Are you concerned about any of the following? *(check any that apply)*

☐ Developmental delay ☐ Autism ☐ ADHD ☐ Anxiety

☐ Cerebral palsy ☐ Vision problems ☐ Hearing problems ☐ Genetic condition

☐ Aggressive or oppositional behavior ☐ Seizures or staring spells ☐ Abnormal movements or tics

☐ Learning disability/School problems ☐ Intellectual disability ☐ Insomnia or sleep problems

☐ Starting a new medication ☐ Options for therapies or behavioral treatments

Has your child been diagnosed with any medical, behavioral, or genetic conditions? ☐ No ☐ Yes,

please list _____

_____

Does your child have any birthmarks? ☐ No ☐ Yes, _____

Has your child had a major head trauma? ☐ No ☐ Yes, _____

Has your child had any surgeries? *(check any that apply)* ☐ None ☐ Ear tubes

☐ Tonsillectomy ☐ Adenoidectomy ☐ Appendectomy ☐ Dental Surgery

☐ Heart Surgery ☐ Brain /Spine Surgery ☐ Orthopedic/Bone Surgery ☐ Other_____

Medications	☐ None	☐ Yes, *list:*	_____
Vitamins	☐ None	☐ Yes, *list:*	_____
Supplements	☐ None	☐ Yes, *list:*	_____
Medication Allergies	☐ None	☐ Yes, *list:*	_____
Immunizations up to date	☐ Yes	☐ No	_____
Prior brain imaging	☐ None	☐ Yes,	☐ MRI ☐ CT ☐ ultrasound *(check which apply)*
Prior IQ or behavioral test	☐ None	☐ Yes, *list:*	_____
Hand preference	☐ Right	☐ Left	☐ Both the same ☐ Unsure

If needed, list additional any details on the back of the form or a separate paper

Pregnancy and Birth History:

Age of mother at delivery of child:_____ What number pregnancy was this for mother? _____

Out of how many total pregnancies? _____ Any history of miscarriages or stillbirths? _____

Were any of the following a concern *during* pregnancy?

	No	Yes	*please provide additional details in the space below*
Fevers/Infections	☐	☐	
High blood pressure/Pre-eclampsia	☐	☐	
Diabetes	☐	☐	
Seizures	☐	☐	
Abnormal bleeding	☐	☐	
Early/Premature labor	☐	☐	
Trauma or accidents	☐	☐	
Concerns about baby's movements	☐	☐	
Concerns about baby's growth	☐	☐	
Abnormal prenatal testing	☐	☐	
Medication use (specify which)	☐	☐	
Alcohol use	☐	☐	
Cigarette/Tobacco Use	☐	☐	
Other substance use	☐	☐	
Late or no prenatal care	☐	☐	

Where was your child born? _____

Was your child born at **term (37- 40 weeks of pregnancy)**? ☐ Yes ☐ No, # _____ weeks

Method of delivery: ☐ Vaginal ☐ C-section, *specify reason*_____

Were any of the following a concern *during delivery* or *after* your child was born?

	No	Yes	*please provide additional details in the space below*
Forceps assisted delivery	☐	☐	
Vacuum assisted delivery	☐	☐	
Fetal distress	☐	☐	
CPR or resuscitation at birth	☐	☐	
NICU admission	☐	☐	
Antibiotics/Infections	☐	☐	
Ventilator or oxygen support	☐	☐	
Jaundice/Bilirubin lights	☐	☐	
Temperature Control/Incubator	☐	☐	
Seizures	☐	☐	
Feeding problems	☐	☐	
Glucose/blood sugar control	☐	☐	
Nursery stay lasting 4+ days	☐	☐	
Other	☐	☐	

Pregnancy and Birth History, continued:

Did your child pass their newborn hearing screen? ☐ Yes ☐ No ☐ unsure

Did your child pass their newborn heart screen? ☐ Yes ☐ No ☐ unsure

Did your child have a normal newborn screen (heel prick blood test)? ☐ Yes ☐ No ☐ unsure

Family History

Do any of the following conditions run in the child's immediate family? *(please limit responses to blood-related parents, siblings (full and half), grandparents, aunts/uncles, and first cousins only)*

	No	Yes,	*please list **who** has the condition in the space below*
Developmental Delay	☐	☐	
Autism	☐	☐	
ADHD	☐	☐	
Epilepsy/Seizures	☐	☐	
Cerebral Palsy	☐	☐	
Genetic Condition	☐	☐	
Learning Disability/School Difficulty	☐	☐	
Intellectual Disability	☐	☐	
Tics or Tourette Syndrome	☐	☐	
Nerve or Muscle Disease	☐	☐	
Sudden or Unexplained Death	☐	☐	
Severe Childhood Illness	☐	☐	
Anxiety and/or Depression	☐	☐	
Other Mental Health Condition	☐	☐	

Other medical conditions in the family _____

Developmental History:

If your child has achieved any of the following developmental milestones, what age did they begin to show these skills? (as best as you can recall)

	Age		Age
Roll over		Scribble	
Sit alone		Use spoon/fork	
Walk		Write name	
Babble		Know colors	
Use a single word to name someone or something		Count to 10	
Speak in 2-word sentences		Recognize ABC's	
Finger feed		Toilet training	

Developmental History, continued:

Has your child ever lost any skills or had a regression in development? ☐ No ☐ Yes, please provide details _____

_____

_____

Care, Education, and Services:

Does your child generally stay home during the day or attend a school or daycare program?

(check any that apply) ☐ stays at home ☐ daycare ☐ preschool ☐ school, grade level _____

Primary caregivers for child at home _____

If applicable:

Current School/Daycare: _____ ☐ public ☐ private ☐ home school

Does your child have an ☐ IEP or a ☐ 504 plan at school? *(if YES, check which one)*

What services and/or accommodations are included? *(check any that apply)*

☐ speech therapy ☐ occupational therapy ☐ physical therapy ☐ behavioral therapy/counselor

☐ extra time for homework or tests ☐ hearing accommodations ☐ vision accommodations

☐ special education classroom ☐ autism or emotional support ☐ 1:1 support aide

☐ other: _____

Therapies:

If your child receives therapies, where do they receive them (e.g., Early Intervention, Intermediate Unit, School-based, Outpatient) and how often (e.g., 30 min/week)?

	Location	Frequency
Speech Therapy		
Occupational Therapy (OT)		
Physical Therapy (PT)		
Developmental Therapy (DT)		
Special Instruction (SI)		
ABA Therapy		
Other Behavioral Therapy		
Vision Therapy		
Other:		

Anything else you would like us to know about your child: _____

_____

_____

_____

_____