La Jolla Developmental Pediatrics
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Contact Information

Child's Name (Last, First): _____

Date of Birth: _____ Age: _____ Sex (cirle one): M F

Mother/Guardian: _____

Father/Guardian: _____

Address: _____

City/State/Zip: _____

Telephone Number(s): Home: _____Office: _____Mobile: _____

Email address: _____

Child's Doctor:_____ Doctor's Phone:_____

Name of Person Completing this Form: _____

Relationship to Child:_____

Chief Concern

1. Who suggested this child be seen by the doctor for attention, school, or behavior problems?

   _____

2. What concerns do you have about your child?

   _____

   _____

   _____

3. How long have you been concerned about the child's behavior?

   _____

4. (Circle one) overall, the above concerns are: **mild** **moderate** **severe**

5. (Circle one) my concerns are: **improving** **staying the same** **getting worse**

Chief Concern Continued…

6. Please describe the child's strongest areas at home:

_____

_____

7. Please describe the child's weakest areas at home:

_____

_____

_____

History: Birth

1. How much did this child weigh at birth? Pounds _____ Ounces _____
2. Biological father's age at birth of this child:

_____

3. Biological mother's age at birth of this child:

_____

4. Number of pregnancies prior to this child:

_____

5. Number of miscarriages prior to this child:

_____

6. Multiple births: (circle one) Yes No
7. Did the mother use any substances or medications during the pregnancy? (circle all that apply):

a. Beer/wine b. Alcohol c. Prescription medications d. cocaine

e. tobacco f. Marijuana g. Methamphetamine (crystal/ice)

h. Other: _____

8. Where there any problems during the pregnancy? (circle one) Yes No
   If yes, please specify:
9. Was this child born by Cesarean/C-section? (circle one) Yes No

   If yes, circle appropriate response: Planned Emergency
10. Was this child born two of more weeks before the "due date"? (circle one)

    Yes No

    If yes, how many weeks early was this child? _____ weeks

History: Newborn	Yes	No	If yes, please explain
Newborn jaundice			
Admitted to the newborn intensive care unit			
Required oxygen/intubation			
Was infant discharged with mother			

History: Developmental	Yes	No
Did this child roll over by 5 months?		
Did this child crawl by 10 months?		
Did this child walk by 15 months?		
Age of first word noted _____ < 12 month _____ > 12 months		
Did this child speak 2 word sentences by 2 years?		
Could strangers understand this child by 3 years?		
Did this child read simple words by 6 years?		
Age when fully bladder trained _____		
Age when fully bowel trained _____		
Is your child able to dress his/her self?		

History: Speak & Language	Yes	No
Listening concerns		
Does your child have difficulty listening?		
Does your child misunderstand spoken directions?		
Does your child confuse speech sounds?		
Does your child misunderstand figures of speech/ sarcasm?		
Speaking Concerns		
Does your child have difficulty with speaking?		
Does your child have slow or labored speech?		

History: Speak & Language continued…	Yes	No
Does your child jumble up sounds in words?		
Does your child have difficulty telling a story from beginning to end?		
Does your child use grammar incorrectly?		
Which is your child's primary language?		
Which languages are spoken at home?		

History: Behavior	Yes	No	If yes, please explain
Did this child cry frequently as an infant?			
Was this child difficult to calm down as an infant?			
Did this child have trouble sleeping as an infant?			
Was this child a picky or irregular eater as an infant?			
Did this child have many temper tantrums as a toddler?			
Did you have trouble keeping a babysitter because of this child's behavior?			
Does this child have stool/ bowel accidents?			
Emotional Concerns			
Does your child have daytime urine accidents?			
Does your child have temper tantrums?			
Does your child bang his/her head?			
Does your child hold his/her breathe when upset?			
Does your child cry easily?			
Is your child physically aggressive towards others?			
Is your child verbally aggressive towards others?			

History: Behavior	Yes	No	If yes, please explain
Mood			
Does your child appear sad, empty or irritable much of the time?			
Does your child make negative comments about him/herself?			
Is your child often withdrawn?			
Is your child uninterested in participating in many activities?			
Has your child talked about harming him/herself?			
Anxiety			
Does your child excessively worry?			
Does your child experience frequent unfounded illness or pain?			
Does your child avoid going to school?			
Does your child have more fears than other children do?			
Obsessions/ Compulsions?			
Does your child insist upon doing things his/her way?			
Does your child perform repetitive movements such as rocking or flapping?			
Does your child insist on having things done in a certain way all of the time?			
Does your child line up his/her toys?			
Does your child have difficulty making transitions?			
Social Skills			
Does your child have difficulty in conversing with others?			
Does your child have difficulty making friends and acquaintances?			

History: Social Skills continued…	Yes	No	If yes, please explain
Does your child have difficulty understanding the body language of others?			
Does your child have problems understanding other people's perspective?			
Sensory Processing			
Is your child a picky eater/ food sensitivities?			
Is your child overly sensitive to certain sounds?			
Does your child show an aversion to textures of clothing?			
Is your child sensitive to touch?			
Does your child frequently bump into objects, trip or fall?			
Any other sensory concerns:			

HISTORY: Attention	Yes	No
Processing Concerns		
Do background noises and extraneous activities easily distract your child?		
Does your child have difficulty concentrating?		
Do you frequently have to repeat instructions for your child?		
Does your child have difficulty remembering recently learned information?		
Does your child frequently daydream and "space out"?		
Does your child tend to focus on irrelevant information?		
Does your child have difficulty delaying gratification?		

HISTORY: Attention continued…	Yes	No
Production Concerns		
Is your child impulsive?		
Does your child say and do things in an inappropriate manner?		
Does your child have difficulty staying on task?		
Does your child overreact to minor situations?		
Does your child have difficultly recognizing his/her mistakes?		
Does your child show indifference to punishment and or rewards?		
Does your child have difficulty learning from his/her mistakes?		
Planning and Organization Concerns		
Does your child have difficulty planning?		
Does your child have difficulty establishing priorities?		
Does your child loose things frequently?		
Is your child's room frequently messy?		
Is your child frequently messy?		
Is your child frequently bored?		
Does your child procrastinate?		

History: Sleep	Yes	No
Does your child have trouble falling asleep at night?		
Does your child have problems staying asleep?		
Does your child have very heavy sleep?		
Does your child snore or have noisy breathing during sleep?		
Does your child often have nightmares?		
Does your child take frequent naps during the day?		
Is your child frequently tired during the day?		
How long does it take your child to fall asleep? _____ minutes		
How much sleep does your child get each night? _____ hours		

History: Medical	Yes	No
Has this child had any major health problems? Specify:		
Has this child had frequent ear infections?		
Has this child ever had hearing problems?		
Has this child ever been hospitalized or had surgery? Specify:		
Has this child had meningitis or encephalitis? Specify:		
Has this child had seizures?		
Has this child had any difficulties with growth? Specify:		
Does this child have any birth defects or birthmarks? Specify:		
Does this child have any problems with his/her weight? Specify:		
Has this child had frequent headaches?		
Does this child have any trouble with nose/mouth/throat including swallowing?		
Does this child have any heart problems (heart murmur, ECG or history of heart tests)?		
Does this child have history of lung problems including asthma or wheezing?		
Does this child have frequent stomach or abdominal problems (vomiting, stomachache, or constipation)?		
Does this child have any allergies? Specify:		

History: ADHD

1. Has this child ever been diagnosed with ADHD or ADD in the past**? (circle one) Yes No**

   If yes: Year: _____ Month: _____ and where was the evaluation completed?_____

2. Had this child ever taken medication for ADHD or ADD in the past? (circle one) Yes No

   If yes, please provide the following**: Name**: _____

   Dose :_____ **Date**s:_____

   Where you satisfied with the medication's effect on this child's symptoms?

   (circle one) Yes No

3. Has this child ever received psychological counseling for any problems? (circle one) Yes No

   If yes, please specify:

   _____

4. Is this child currently taking any vitamins or herbal supplements? (circle one) Yes No

   If yes, please specify:

   _____

5. Are there are professionals (such as doctors, psychiatrists, social workers, occupational therapists, or physical therapists) currently involved in this child's care?

   (circle one) Yes No

   If yes, please list them and the role they take in your child's care?

   _____

History: Medication		
Past Medication(s): Name of medications used for long time in the past:	**Dosage(s)**	**Dates**
a.		
b.		
c.		
Current Medication(s): Name of medications currently taking:	**Dosage(s)**	**Dates**
a.		
b.		
c.		

Child's Health				
Check the box that best describes your child's behavior over the past 6 months. If your child is currently taking medication, please rate your child's behavior on the medication.				
	Never/Rarely 0	Occasionally 1	Often 2	Very Often 3
Fails to give close attention to detail or makes careless mistakes (e.g. homework).				
Has difficulty attending to what needs to be done.				
Does not seem to listen when spoken to directly.				
Does not follow through when given directions.				

Child's Health continued…				
	Never/Rarely 0	Occasionally 1	Often 2	Very Often 3
Has difficulties organizing tasks and activities.				
Avoids, dislikes, or does not want to start tasks.				
Loses things necessary for tasks or activities (school assignments, pencils, books).				
Is easily distracted by noises or other things.				
Is forgetful in daily activities.				
Fidgets with hands or feet or squirms in seat.				
Leaves seat when he/she is supposed to stay in seat.				
Runs about or climbs too much when he/she is supposed to stay seated.				
Has difficulty playing or starting quiet games.				
Is "on the go" or acts as if "driven by a motor."				
Talks too much.				
Blurts out answers before questions have been completed.				
Has difficulty waiting his/her turn.				
Interrupts or bothers others when they are talking or playing games.				
Argues with adults.				
Loses temper.				
Actively disobeys or refuses to follow adult's request or rules.				
Bothers people on purpose.				
Blames other for his or her mistakes or misbehaviors.				
Is touchy or easily annoyed by others.				
Is angry or bitter.				
Is hateful and wants to get even.				
Bullies, threaten, or scare others.				

Child's Health continued…				
Check the box that best describes your child's behavior over the past 6 months. If your child is currently taking medication, please rate your child's behavior on the medication.				
	Never/Rarely 0	Occasionally 1	Often 2	Very Often 3
Starts physical fights				
Lies to get out of trouble or to avoid jobs (e.g. "cons" others).				
Skips school without permission.				
Is physically unkind to people.				
Has stolen things that have value.				
Destroys others' property on purpose.				
Is physically mean to animals.				
Has set fires on purpose to cause damage.				
Has broken into someone else's home, business, or car.				
Has stayed out all night without permission or run away from home overnight.				
Has used a weapon that can cause serious physical harm (e.g. bat, broken bottle, brick).				
Is fearful, anxious, or worried.				
Is afraid to try new things for fear of making mistakes.				
Feels useless or inferior.				
Blames self for problems, feels at fault.				
Feels lonely, unwanted, or unloved; complains, "no one loves me."				
Is sad or unhappy.				
Feels different and easily embarrassed.				
Is overly concerned about health/body.				
Has problems getting along with you.				
Has problems getting along with others his/her own age.				
Has problems getting along with his/her own siblings.				

Child's Health continued…				
Check the box that best describes your child's behavior over the past 6 months. If your child is currently taking medication, please rate your child's behavior on the medication.				
	Never/Rarely 0	Occasionally 1	Often 2	Very Often 3
Has problems in group activities such as games or team play.				
Decreased interest or pleasure in all, or almost all, activities of the day.				
Has said things like "I wish I were dead" or has tried to hurt self.				
Recurrent excessive distress when separation from home or caretakers.				
Has distinct periods of unusually irritable or unusually cheerful mood (different from normal).				
Has prolonged temper tantrums (greater than 20-30 minutes).				
Hears voices others do not hear.				
Has compulsions (e.g. child seems driven to wash hands, count, erase until holes appear).				
Has obsessions (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
Has recurrent recollections or dreams of a traumatic event.				
Seems to avoid or have phobias of specific people, animals, things or situations.				
Seems unaware of others existence, is uninterested in interacting with others.				
Has odd, eccentric or unusual preoccupations (e.g. clothing items, toys, neatness)				
Appears uninterested in activities children his or her age usually like or participate in.				
Has experimented with or abused drugs of alcohol.				

History: Family Medical Problems: Is there anyone in this child's family with the following:				
	Yes	No	Don't know	If yes, how is this person related to this child?
Neurologic problems				
Learning or reading difficulty				
Cognitive insufficiency				
ADHD/ ADD (attention problems/ hyperactivity)				
Tics or Tourette's disorder				
Speech problems				
Autism spectrum disorders				
Anxiety/ compulsions				
Depression				
Bipolar Disorder/ Manic depression				
Schizophrenia				
Alcohol or Drug problems				
History of physical or sexual abuse				
Trouble with the law				
Medications for nerves or emotional problems				
Thyroid problems				
Exposure to toxic chemicals				
Cardiac problems or sudden death?				
Any family history of early cardiac deaths <50 years?				

Family Support:

1. Does your child have siblings? Yes No
   Ages: _____
2. Is your child adopted? (circle one) Yes No
3. Is your child in foster care? (circle one) Yes No
4. Are the parents separated? (circle one) Yes No
5. Are the parents divorced? (circle one) Yes No
6. Who has legal custody of your child?
   _____

Family Support continued…

7. Do you have family or social support locally?

   _____

8. Is there anything unusual about this child's living arrangement that you would like to discuss with the child's doctor?

   _____

History: Social

1. Have there been any major changes or stresses in this child's life (e.g. marital problems, a move, change of school, birth of a brother/sister, the death of a pet)?
   (circle one) Yes No
   If yes, please specify and include how old the child was at the time:

   _____

   _____

2. Has there been a serious illness or death in a parent or close family member of this child? (circle one) Yes No
   If yes, please specify and include how old the child was at the time:

   _____

   _____

3. Has this child experienced or seen any traumatic events (e.g. domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? (circle one)
   Yes No
   If yes, please specify and include how old the child was at the time:

   _____

   _____

   _____

4. Are any major changes or stresses expected in the future?
   (circle one) Yes No
   If yes, please specify:

   _____

   _____

   _____

History: Education

1. Please describe this child's strongest areas in his/her schoolwork:

_____

_____

2. Please describe this child's weakest areas in his/her schoolwork:

_____

_____

3. Current School/Grade:

_____

_____

History: School Intervention

1. Has this child been in an Early Intervention program or Special DayCare/Preschool? (circle one) Yes No
2. Has this child had speech, occupational or physical therapy? (circle one) Yes No
3. Has this child ever considered/attended summer school? (circle one) Yes No
   If yes, specify subject(s) and grade(s):

   _____

   _____
4. Has this child ever repeated a grade/teacher discussed repeating a grade? (circle one) Yes No
   If yes, specify:

   _____

   _____
5. Does your child have an individual plan (like a 504 plan or IEP)? (circle one) Yes No
   If yes, specify and describe any special education services:

   _____

   _____

   _____
6. Have any disciplinary actions been taken (detentions, suspension, or expulsion)? (circle one) Yes No
   If yes, specify:

   _____

   _____

History: School Intervention continued…

7. Does the child need any special medical assistance? (circle one) Yes No

   If yes, specify:

   _____

   _____

8. Has your child's school preformed a psycho educational evaluation? (circle one) Yes No

   If yes, specify date/specifics:

   _____

   _____

9. Is your child receiving educational support outside of school? (circle one)

   Yes No

   If yes, specify:

   _____

   _____

History: School Problems				
For each of the following grades this child has completed, were any problems reported? If yes, please describe the teacher or parent concerns in the space provided.				
	Yes	**No**	**Name of School**	**Behavior/Academics**
Preschool				
Kindergarten & 1st Grade				
2nd & 3rd Grade				
4th & 5th Grade				
6th through 8th Grade				
High School				

Has your child had difficulty learning any of the following:	N/A	Yes	No
Writing the alphabet			
Sounding out words			
Spelling accurately			
Understanding what he/she needs			
Reading fast enough			
Telling time			
Writing neatly			
Remembering instructions for an assignment			
Performing math calculations			
Understanding math word problems			
Drawing pictures			
Managing his/her homework			
Knowing how to study for a test			
Writing reports			

History: Summary:

Please summarize your child's OVERALL functioning (i.e. emotionally, behaviorally, socially, academically, etc.) by choosing ONE number below. Compare your child's functioning in 3 settings--home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. Please circle only one number.

1. Excellent functioning/ No impairment in settings
2. Good functioning/ Rarely shows impairment in settings
3. Mild difficulty in functioning/ Sometimes shows impairment in settings
4. Moderate difficulty in functioning/ Usually shows impairment in settings
5. Severe difficulties in functioning/ Most of the time shows impairment in settings
6. Needs considerable supervision in all settings to prevent from hurting self or others
7. Needs 24-hour professional care and supervision due to severe behavior or gross impairment(s)
8. Do you have any other comments that may be helpful? If yes, please specify:

_____

_____

Signature Page:

I/we certify that the above information is true and correct to the best of my knowledge and belief:

Parent/Guardian:

_____

Parent/Guardian:

_____

Please fax or email completed forms to:
Mary Jane Pionk, MD
Fax: 858.558.7338 **or** Email: forms@lajolladp.com

Please note: If you chose to email the completed form the file size may exceed the size limit of many email sending servers. If your file size exceeds your email sending limit, we suggest that you compress the file, split into smaller files, or use one of the other delivery methods.

If you prefer to send via regular mail, please send to:
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