Center for Developing Minds

NEW PATIENT QUESTIONNAIRE

Date / /

CONTACT INFORMATION

Patient (Child) Name:		Date of Birth:	
Provider's Name:	Telephone Number(s):	Mobile Number(s):	
Mother/Guardian:			
Father/Guardian:			
Address:	City:	State:	Zip Code:
Would you like to receive a periodic newsletter or relevant updates via email? Yes No		Email:	
Medical Insurance:		Policy Number:	
Who completed this form?			

REFERRAL CONCERNS

What concerns do you have about your child?

What do you hope to gain from visiting our center?

Why do you think your child has these issues?

How did you hear about the Center for Developing Minds?:

(PLEASE CIRCLE) Teacher Friend Physician Therapist

Advertisement Website Name: ______________________

If available, please attach photo

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

MEDICAL HISTORY

Mother's Pregnancy History	Yes	No	If yes, please explain
Bleeding during the pregnancy			
Gained less than 20 lbs.			
Gained more than 35 lbs.			
Too high blood pressure			
Too high blood sugar/diabetes			
Physical trauma			
Maternal infections			
Maternal alcohol use			
Maternal tobacco use			
Exposure to other toxins (e.g. cocaine, marijuana)			
Previous miscarriages			
Previous premature births			
Cesarean section			
Forceps assisted delivery			

Length of pregnancy ______weeks   Twins? Yes No

Birth Weight ______lbs. ______oz.   Apgar Scores _____ 1 min _____ 5 min

Patient's Newborn History	Yes	No	If yes, please explain
Newborn jaundice			
Stayed in the newborn intensive care unit			
Transfusion			
Required oxygen			
Intubation			
Was infant discharged with mother?			

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

Patient's Health History	Yes	No	If yes, please explain
General symptoms (fever, weakness, tiredness, etc.)			
Trouble with weight (too little, too much, or major weight changes)			
Trouble with eyes (poor vision, tendency to cross, etc.)			
Trouble with ears or hearing (any specific hearing tests?)			
Ear infections			
Trouble with nose, mouth, or throat (stuffy nose, difficulty swallowing, etc.)			
Heart problems (heart murmurs, ECG or heart tests, etc.)			
Lung problems (asthma or wheezing, tuberculosis, etc.)			
Stomach or abdominal problems (vomiting, stomach ache, constipation, etc.)			
Genital or urinary problems (frequent urination, abnormal genitals, etc.)			
Kidney problems			
Trouble with bones or muscles (weakness, deformities, etc.)			
Skin problems (birthmarks or other skin marks, lumps or bumps, etc.)			
Tics, twitches or makes odd noises			
Headaches			
Loss of consciousness/head injury			
Seizures/Convulsions			
Meningitis/infection of the brain			
Body stiffness			
Body looseness or floppiness			
Wets underwear during day			
Wets bed at night			
Soils underwear/bowel accidents			
Serious illness (in bed and unresponsive for several days)			
Lead poisoning			
Allergies			

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

Patient's Health History cont.	Yes	No	Dates and Purpose
Hospitalization			
Surgeries			

MEDICATION HISTORY

Past Medication(s) **Name of medications used for a long time in the past:**	**Dosage(s)**	**Dates**
Current Medication(s) **Name of medications currently on:**	**Dosage(s)**	**Dates**

SLEEP HISTORY	Yes	No
Does your child have trouble falling asleep at night?		
Does your child have problems staying asleep?		
Does your child snore or have noisy breathing during sleep?		
Does your child have very heavy sleep?		
Does your child take frequent naps during day?		
Is your child frequently tired during the day?		

How long does it take your child to fall asleep? ________ minutes

How much sleep does child get each night? ________ hours

 This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

DEVELOPMENTAL HISTORY

(Please check appropriate box for each row)

Developmental Milestone	Cannot Recall	0-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	4-5 years	5-6 years
Rolled over									
Sat up without support									
Crawled									
Spoke first words (Mama, Dada, etc.)									
Walked alone (10 steps)									
Walked up stairs									
Put words together (Daddy bye-bye, Mama home, etc.)									
Spoke 2-3 word sentences									
Fully bladder trained									
Fully bowel trained									
Caught a big ball									
Spoke clearly so strangers understood									
Able to dress self									
Able to tie shoelaces									

SPEECH AND LANGUAGE HISTORY

	Yes	No
Listening		
Does your child have difficulty with listening?		
Does your child misunderstand spoken directions?		
Does your child confuse speech sounds?		
Does your child misunderstand figures of speech or sarcasm?		
Speaking		
Does your child have difficulty with speaking?		
Does your child have slow or labored speech?		
Does your child use grammar incorrectly?		
Does your child jumble up sounds in words?		
Does your child have difficulty telling a story from beginning to end?		

Which languages are spoken at home?	Which is your child’s primary language?

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

BEHAVIOR HISTORY	Yes	No
Emotional Response		
Does your child bang his/her head?		
Does your child have temper tantrums?		
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?		
Mood		
Does your child appear sad, empty or irritable much of the time?		
Is your child uninterested in participating in many activities?		
Does your child make negative comments about him/herself?		
Is your child overly withdrawn?		
Has your child talked of 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 or Perseverations		
Does your child insist upon doing things his/her way?		
Does your child have difficulty making transitions?		
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?		
Social Skills		
Does your child have difficulty in conversing with others?		
Does your child have difficulty understanding the body language of others?		
Does your child have problems “acting cool”?		
Does your child have problems taking other people’s perspective?		
Does your child have difficulty making friends and acquaintances?		
Sensory Processing		
Does your child frequently bump into objects, trip or fall?		
Is your child a picky eater?		
Is your child overly sensitive to certain sounds?		
Does your child show an aversion to textures of clothing?		

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

ATTENTION HISTORY	Yes	No
Mental Energy		
Is your child frequently tired during the day?		
Does your child have highly inconsistent patterns of attention?		
Does your child have difficulty initiating and or completing work?		
Does your child have inconsistent school performance?		
Does your child tend to work on things that only interest him?		
Processing Controls		
Do background noises and extraneous activities easily distract your child?		
Does your child tend to focus on irrelevant information?		
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 have difficulty concentrating?		
Does your child miss parts of explanations and information?		
Does your child have difficulty delaying gratification?		
Production Controls		
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 have difficulty recognizing his/her errors?		
Does your child have difficulty learning from his/her mistakes?		
Does your child show indifference to punishment and or rewards?		
Does your child overreact to minor situations?		
Planning and Organization Controls		
Does your child loose things of value?		
Is your child's room frequently messy?		
Is your child frequently bored?		
Does your child have difficulty planning?		
Does your child have difficulty establishing priorities?		
Does your child procrastinate and dawdle?		

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

EDUCATION HISTORY

Current School and District:	Grade:
School Contact and Phone Number:	Previous Schools Attended, Location:
School Address:	

Special Education Services

Please describe any special education services that your child has received:	Year Received

Why does your child receive special education services?

		Yes	No
Does your child have a 504 plan?			
Does your child have an individualized education plan (IEP)?			
Has your child's school performed a psychoeducational evaluation?			
Is your child receiving educational support outside of school?			
Has your child had difficulty learning any of the following:	**N/A**		
Writing the alphabet			
Telling time			
Sounding out words			
Spelling accurately			
Understanding what he/she reads			
Reading fast enough			
Writing neatly			
Drawing pictures			
Performing math calculations			
Understanding math word problems			
Writing reports			
Remembering instructions for an assignment			
Knowing how to study for a test			
Managing his/her homework			

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

FAMILY INFORMATION

Family History	Mother	Father	Brother(s)	Sister(s)	Other Relatives
Learning difficulties					
Trouble paying attention					
Hyperactivity					
Autism Spectrum Disorders					
Mental Retardation					
Drug or alcohol abuse					
Speech problems					
Depression					
Anxiety/Compulsions					
Manic Depression					
Other					

Who Lives at Home?

Name	**Relationship**	**Age**	**Occupation**

Family Supports	**Yes**	**No**
Does your child have siblings that are not living at home?		
Is your child adopted?		
Is your child in foster care?		
Are the parents separated?		
Are the parents divorced?		
Who has legal custody of your child?		

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.

INTERESTS AND STRENGTHS

Describe your child's particular interests?

What are your child's strengths and talents?

Please include any other information you think might be valuable?

PROFESSIONAL SUPPORTS

Please list the other clinicians caring for your child (e.g. counselors, physicians)

Name	Specialty	Address	Phone Number

Return completed form to: **Center for Developing Minds**
15951 Los Gatos Blvd. Suite 6
Los Gatos, CA 95032

Questions call: 408.358.1853

This form is the property of the Center for Developing Minds Medical Corp. Unauthorized use is prohibited.