Thousand Oaks Pediatrics
Pediatrics, Adolescent Medicine, Developmental Pediatrics, Special Needs
Stephen P. Kundell, M.D. Laila Niazi, M.D.

Dear Parent:

Attached are documents for you to complete prior to the behavioral/developmental assessment with Dr. Kundell. If other agencies such as Regional Center or CCS have seen the child, we will need to obtain those records. Also, we need to receive any records from psychologists, occupational or physical therapists, neurologists, prior pediatricians, or schools which are relevant to the problems for which you are requesting an assessment from Dr. Kundell.

We will schedule an appointment for consultation after the documents are received back. You may return them in person, by mail, or fax, whatever is most convenient.

Thank you.

Thousand Oaks Pediatrics

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BEHAVIORAL/ DEVELOPMENTAL QUESTIONNAIRE
STEPHEN P. KUNDELL, MD

IDENTIFICATION

Date_____

Patients Name_____Birthdate_____

Home Phone _____Work Phone_____

Person(s) Completing Form _____Relationship_____

Referral Source_____

REASON FOR EVALUATION

State the nature, duration, frequency, and severity of the problems that have led to this evaluation

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

At what age did you first have concerns of your child's development or behavior, and what concerned you?

_____

_____

_____

_____

What other physicians, psychologists, agencies, or clinics are currently or previously have been consulted for help with this problem? (give approximate dates)

_____

_____

_____

_____

What is your understanding of the possible causes of your child's problem? Provide any comments that you think may be helpful in my understanding of your child's situation (continue on back if necessary).

_____

_____

_____

_____

_____

What types of treatments have been used to help (therapies, medications, other)

_____

_____

_____

_____

_____

Has anyone else in your family had a similar problem? (if yes, please describe)

_____

_____

_____

FAMILY HISTORY PART I

Mother's Name_____Birthdate_____
Marital Status_____ Prior Marriages _____
Highest School Level Completed_____
Occupation_____Employer_____
No.of pregnancies_____ No.of living children _____
General Health _____

Father's Name_____ Birthdate_____
Marital Status_____ Prior Marriages_____
Highest School Level Completed _____
Occupation_____Employer_____
General Health_____

Siblings (continue on reverse if necessary)

Name	Birthdate	Grade/Employed	Living at home?	Overall Health

Have there been concerns over the development or school progress of either parent or any of your other children?

_____
_____

Other persons living in the home_____
_____

Name and relationship of other individuals currently important in the patient's life

_____
_____
_____
_____

Have any siblings or close relatives died? _____

Number and location of moves the patient has made in the past 5 years:

_____ _____
_____ _____
_____ _____

FAMILY HISTORY PART II

Are any of the following conditions present in your family? **(Please provide details at the bottom or back of this page, and give information on how the person is related to the patient)**

	Father	Father's Family	Mother	Mother's family	Other children
Learning Problems					
Attention Problems					
Behavior Problems					
Tics or Tourettes					
Compulsive Disorder					
Anxiety/Panic Disorder					
Depression					
Bipolar Disorder					
Autism					
Asperger Syndrome					
Alcoholism					
Substance Abuse					
Physical Abuse					
Other Psychiatric Disorders					
Mental Retardation					
Cerebral Palsy					
Epilepsy					
Migraines					
Other Neurologic Disorders (muscle & nerve disorders, stroke, deafness)					
Genetic Disorder					
Birth Defects					
Miscarriage					
Hereditary Illness					
High cholesterol					
High Blood Pressure					
Cardiomyopathy (weak heart)					
Heart Rhythm problems					
Premature or Sudden Death					
Allergic problems (asthma, hay fever, hives, eczema, food allergies)					
Infectious/Immune (Tuberculosis, hepatitis,venereal disease, parasites, AIDS, weak immunity)					
Chronic Illness (Include heart disease, thyroid, diabetes, kidney, rheumatic disease, bleeding problems, anemia, liver disease, ulcer & intestinal problems, bone disease, eye problems, cancer)					

Details (use extra page if needed):

DEVELOPMENTAL HISTORY

Was this an easy_____ or difficult_____ infant, and why?_____
_____

Please give the ages for the following milestones:
Motor

Rolled over _____Walked stairs alone _____
Reached for objects _____ Rode tricycle _____
Sat alone _____ Rode bicycle _____
Walked alone_____ Finger and thumb grasp_____
Any concerns with large motor development or clumsiness?_____
_____

Language

Cooed_____2 word phrases _____
Laughed_____ Sentences_____
Said "Mama" or "Dada" correctly_____ Gave first & last name_____
6-12 words_____ Recognized colors_____
Used words to indicate needs_____ Counted to 10_____
Did you have any concerns about language development and why?_____
_____

Social/Self-Help

Smiled_____ Played interactive games (tag, etc)_____
Played pat-a-cake or bye-bye_____ Tied shoes_____
Imitated housework_____ Toilet trained-urine_____
Put on clothes_____ Toilet trained-bowel_____
Did you have any concerns over self-help or social behaviors?_____
_____
Is there any history of feeding, swallowing, or chewing difficulties? If yes, please describe:
_____
Any other developmental concerns?_____
_____

Any problems with sports or coordination?
_____
_____

Details:

SCHOOL HISTORY

Current school_____ District_____
Teacher_____ Principal_____ Grade_____
Describe any special school program your child is in_____
_____
Has your child had any special help in the past (tutoring, speech therapy, etc.)? Please describe.
_____
_____
Describe the type of progress your child has made in school_____
_____

Describe any school problems you are aware of_____
_____
_____

Please list all schools attended and describe progress

Type	*Name*	*Dates Attended*	*Progress*
Nursery	_____	_____	_____
Preschool	_____	_____	_____
Kindergarten	_____	_____	_____
Elementary	_____	_____	_____
	_____	_____	_____
Middle school	_____	_____	_____
High school	_____	_____	_____
Other	_____	_____	_____

MEDICAL HISTORY

List all current medications and response to them:
_____
_____
List all prior medications and response to them (use the back if necessary):
_____
_____
_____
_____
_____

Current therapies and response:_____
_____
_____
Prior therapies and
response:_____
_____
_____
_____

SOCIAL, BEHAVIORAL, EMOTIONAL

List all qualities you consider to be your child's strong points_____

_____

What do you like most about your child?_____

_____

What do you dislike about your child?_____

_____

_____

Please make a brief statement about the relationship between the child and:

Mother_____

Father_____

Siblings_____

Behavior problems at home_____

_____

What forms of discipline do you use and how successful are they?_____

_____

Name, age, and sex of child's best friends_____

_____

Any social problems or difficulty making or keeping friends?_____

_____

How would you describe your child's general emotional health?_____

_____

Please describe any emotional or mental health problems that have arisen:_____

_____

What is your child successful at? (sports, hobbies, etc)_____

_____

What has your child found overly difficult?_____

_____

Any history of suicidal thoughts or attempts?_____

_____

Any drug or alcohol use?_____

_____

Any history of physical or sexual abuse?_____

_____

Any problems with appetite or weight?_____

_____

Any bowel or bladder problems?_____

_____

Any unusual thinking or ideas?_____

_____

Use the space below for any additional comments:

_____

_____

_____

_____

_____