UCLA MATTEL Childrens Hospital

Developmental-Behavioral Pediatrics - Intake Form

Dear Caregivers,

This document provides your assessment team at the Developmental-Behavioral Pediatric Program with information to ensure the most productive visit for you and your child. Please complete the Intake Form providing as much information as possible and return it to our program coordinator, Rosaura Cueva, via email, fax or mail as soon as you can, so we can schedule your visit.

Additionally, please send us copies of any developmental-behavioral information on your child, as well as asking any daycare providers, teachers, therapists or other relevant providers to fill out the Provider Questionnaire. These forms ideally would be send before the visit if possible. Please bring the originals to the visit.

Email: DBP@mednet.ucla.edu
Phone: (310) 794 – 1456
Fax: (310) 206 – 4215

Address: Developmental-Behavioral Pediatrics
300 UCLA Medical Plaza, Suite 3300
Los Angeles, CA 90095

Visit checklist:

☐ Intake Form
☐ Teacher/Provider Questionnaire (Please copy the form if your child has multiple providers)
☐ Most recent Regional Center Evaluation / Treatment Plan if applicable
☐ Reports (e.g. Speech-language, Occupational therapy, Psychological evaluation, Behavioral therapy) if applicable
☐ Most recent Individual Education Plan (IEP) AND any School Assessment Reports
☐ A recent video or DVD of your child is also useful in helping us to plan for your visit if you have one available

Date Completed:	**Completed by:**	
Child's Name:	**UCLA ID#:**	
Date of Birth:	**Age:** **Yrs** **Months**	**Gender:** ☐ male ☐ female
Best phone number to reach caregiver:		
1. What are your main concerns about your child's development and/or behavior?		
2. What age was your child when you first became concerned about his/her development or behavior?		
3. What do you hope to gain from this visit?		
4. Describe your child's special qualities and strengths:		

Physician History	
5. Who referred you to the Developmental-Behavioral Pediatrics?	☐ I referred myself
6. Please list any other doctors that your child has seen within the last 3 years	☐ Someone else: Name: _____ Role: ☐ Primary pediatrician ☐ Other:_____ Phone Number: _____-_____-_____
	Name: _____ Specialty: _____
	Name: _____ Specialty: _____
7. Who is your child's primary pediatrician?	Name: _____ Phone Number: _____-_____-_____

Birth History		
Pregnancy, Labor and Delivery History		
8. Mother's age at time of birth:		
9. How many times has the biological mother been pregnant?	_____ How many resulted in a live birth? _____ How many resulted in a miscarriage? _____	
10. Was this child the product of a multiple birth pregnancy?	☐ No ☐ Yes. If yes, please specify:	
11. Was reproductive technology or assistance used for this pregnancy?	☐ No ☐ Yes. If yes, please specify what type:	
12. During pregnancy with this child, did the mother have any of the following?	☐ High blood pressure ☐ Diabetes ☐ Depression or mood swings	☐ Anxiety ☐ Other:
13. Was genetic screening/testing done during the pregnancy? If yes, please indicate the result.	☐ Blood tests: _____ ☐ Amniocentesis: _____ ☐ Chorionic villi sampling: _____	
14. During pregnancy with this child, did the mother take any of the following? If yes, please indicate the name of the medicine.	☐ Pre-natal vitamins / iron ☐ Thyroid medicine ☐ Antibiotics ☐ Blood pressure medicine ☐ Other:	☐ Insulin ☐ Glucophage (Metformin) ☐ Depression medication ☐ Anxiety medication

During pregnancy with this child:	**Yes**	**No**	**Comments**
15. Smoking? How many packs / day?			
16. Drank alcohol? Please specify			
17. Used drugs? If so which?			
18. Is the child adopted?			
	If child is adopted: **At what age did the child come into your home: _____years _____months** **Is the child aware of the adoption?**		

Newborn History	
19. Birth weight?	_____lbs._____oz.
20. Gestational age?	_____weeks (full term is 38-40 weeks)
21. What was the method of delivery?	☐ Vaginal. Were the following used? ☐ Forceps ☐ Suction ☐ C-Section. What was the reason? _____
22. During the delivery, did the mother have any of the following?	☐ High blood pressure ☐ Fever ☐ Other problem:
23. During the delivery, did the child have any problems?	
24. Was the child admitted to the neonatal intensive care unit (NICU)?	☐ No ☐ Yes. If yes, please specify Why: _____ How many days were they in the NICU? _____days
25. Did the child require any of the following while a baby?	☐ A ventilator. If yes, how many days? _____ ☐ Require oxygen. If yes, how many days? _____ ☐ Antibiotics: _____ ☐ Help with feeding problems: _____ ☐ Treatment for jaundice (yellow). ☐ No ☐ Yes Did they need lights to treat? ☐ No ☐ Yes ☐ Other treatments or tests:

Early Childhood History		
26. When did your child accomplish the following?		
Language/Communication	• Made eye contact: _____months • Waved bye: _____months • Pointed to objects: _____months • Responded to name: _____months • Indicated that he/she wants something using gestures: _____months • Said mama or dada specific for that person: _____months • Said first words besides mama or dada: _____months • What were first words: _____ • Indicated that he/she wanted something using words: _____months • Said two words together (such as "want milk"): _____months • Spoke in sentences: _____months	
Movement/Motor skills	• Rolled over: _____months • Sat alone: _____months • Crawled: _____months • Fed self with fingers: _____months • Walked alone: _____months • Walked up and down stairs holding rail: _____months • Scribbled with a crayon/marker: _____months • Was toilet trained: _____months	
Can your child do the following yet?	☐ Eat with utensils ☐ Drink from an open cup	☐ Dress him/herself ☐ Undress him/herself
27. Did your child ever reach a milestone and then lose the ability to do it?	☐ No ☐ Yes. If yes, please specify The milestone(s) and age lost:	

Developmental/Behavioral History	
28. Please describe typical foods your child eats.	
29. Describe a typical day for your child, including interests and activities.	
30. What does your child play with/what interests does your child have?	
31. Does your child have pretend play with toys? If so, please give some examples.	
32. Please provide a description of how your child interacts with peers	
33. Please provide a description of how your child interacts with family members	
34. How does your child communicate with you?	☐ Gestures ☐ Words. Please list 2-3 examples: _____ ☐ Phrases. Please list 2-3 examples: _____ ☐ Sentences. Please list 2 examples: _____
35. Does your child have any of the following?	☐ Unusual or repetitive body movements or utterances. If yes, please describe: _____ ☐ Strong adherence to rituals or routines If yes, please describe: _____ ☐ Intense fixations or obsessions If yes, please describe: _____

Health History	
36. Has your child ever been hospitalized? ☐ No ☐ Yes	If yes, please specify Reason(s) and date(s):
37. Has your child ever had surgery? ☐ No ☐ Yes	If yes, please specify Reason(s) and date(s):
38. Immunization status:	☐ Up to date ☐ Other:
39. Does your child have any allergies to medications, foods or any environmental factors: ☐ No ☐ Yes	If yes, please specify Allergen and type of reaction(s):
40. Current Medications:	☐ No ☐ Yes. If yes, please specify:

41. Has your child had any of the following evaluations? If yes, please indicate when, where and the result.	☐ MRI ☐ CT ☐ EEG ☐ Sleep study ☐ Hearing:	☐ Genetic testing ☐ Vision: ☐ Other:
42. Is your child receiving any complementary or alternative treatments?	☐ No ☐ Yes. If yes, please indicate what kind: ☐ Special diet: _____ ☐ Other:	

Does your child currently have any of the following medical problems?		
Medical Problems	Yes	Comment below if "Yes"
43. Problems with vision?		
44. Problems with hearing?		
45. Serious/chronic health problems (e.g. diabetes)?		
46. Birth defects or birth marks?		
47. Serious infection/illness?		
48. Serious injury, burn or broken bones?		
49. Head injury or loss of consciousness?		
50. Frequent accidents or multiple minor injuries?		
51. Fainting spells or dizziness?		
52. Seizures, convulsions or staring spells?		
53. Motor / Vocal tics (blinking, throat clearing)?		
54. Compulsive mannerisms (hand washing, counting)?		
55. Suicidality		
56. Frequent headaches? Migraines?		
57. Repeated ear infections? Ear tubes?		
58. Serious nose, mouth or throat problems?		
59. Thyroid or other hormone problems?		
60. Lung problems (asthma, pneumonia)?		
61. Too fast heart beat (palpitations) or chest pain?		
62. Frequent stomach aches?		
63. Problems with vomiting, diarrhea or constipation?		
64. Problems with kidney, bladder or urine?		
65. Blood problems (anemia, low blood count)?		
66. Poisoning or exposure to toxic chemicals (lead)?		
67. Problems with restless sleep or snoring?		
68. Difficulties with diet or appetite?		
69. Small for age or underweight / Overeats or overweight?		
70. Other:		

Has your child been diagnosed or been suspected of (by you or anyone else) the following:				
Conditions	Yes	Diagnosed. If yes, by whom	Yes	Suspected of having
Learning disabilities				
ADHD/ADD				
Depression				
Bipolar				
Obsessive Compulsive Disorder				
Autism spectrum Disorder				
Intellectual Disability / MR				
Language delay				
Tuberous Sclerosis				
Down Syndrome				
Fragile X Syndrome				
Neurofibromatosis				
Cerebral Palsy				
Fetal Alcohol Syndrome				
Other:				

Family Constellation					
Child lives with: (Birth mother/Father, Stepmother/Father, Adoptive Mother/Father, Foster Mother/Father, Guardian, Other:_____)					
Relationship	Name	Age	Highest Level of School	Living at Home	Occupation
Parents:					
				☐ Yes ☐ No	
				☐ Yes ☐ No	
Siblings:					
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
Others at home:					
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

71. Child care arrangements / Preschool?	
72. Any special circumstances in the family situation?	

Biological Family Medical and Psychiatric History			
Does anyone in this child's biological family have:	Yes	No	Relationship to the child
Problems with sustaining attention?			
ADHD			
Behavior problems as a child, if so what?			
Behavior problems as a teen, if so what?			
Speech or language problems, if so what?			
Neurological problems (seizures, etc), if so what?			
Intellectual Disability (mental retardation)?			
Birth defect, if so what?			
Tics/Tourette's Syndrome			
Autism Spectrum Disorder			
Thyroid Problems			
Heart problems before age 50			
Physical Abuse			
Mental Abuse			
Sexual Abuse			
Depression			
Bipolar Disorder			
Anxiety /Panic attacks			
Obsessive Compulsive Disorder			
Problems with alcohol abuse			
Substance Abuse Problems (other than alcohol)			
Other:			

Community Therapy Services				
73. Has your child been referred to Regional Center?	☐ No ☐ Yes. If yes, when and by whom: Which Regional Center?			
74. Does your child receive any of the following services?	Through what source (Regional Center **RC**; School District **SD**; Insurance **I**; Private Pay **P**)			
	Yes	Hours/month	Name	Funding Source:
Speech-Language Therapy				☐RC ☐SD ☐I ☐P
Occupational Therapy				☐RC ☐SD ☐I ☐P
Physical Therapy				☐RC ☐SD ☐I ☐P
Infant Stim				☐RC ☐SD ☐I ☐P
Early Intervention Program				☐RC ☐SD ☐I ☐P
Social Skills Training				☐RC ☐SD ☐I ☐P
Behavioral Therapy				☐RC ☐SD ☐I ☐P
Family Therapy				☐RC ☐SD ☐I ☐P
Psychologist/Therapist				☐RC ☐SD ☐I ☐P
Other Therapies:				
				☐RC ☐SD ☐I ☐P
				☐RC ☐SD ☐I ☐P
				☐RC ☐SD ☐I ☐P