Rady Children's Hospital San Diego

Rady Children's Hospital-San Diego
DEC and ADI
3020 Children's Way
San Diego, CA. 92123-4282

*DTF14

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Developmental Re-Evaluation Questionnaire

IDENTIFICATION

Child's Name: _____ Birthdate: _____ Sex: ❒ Male ❒ Female Age: _____

Child's Primary Care Physician: _____

Person completing this form: _____ Date: _____

Relationship to Child: _____ _____

STATEMENT OF THE PROBLEM

Describe as completely as possible the reason for re-evaluation: _____

_____

GENERAL DEVELOPMENT

A. FAMILY HISTORY
Please list any family changes since the previous evaluation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have any relatives (including parents, grandparents, siblings, aunts, uncles, cousins) been diagnosed with any of the following since the previous evaluation?

	YES	NO	IF YES, WHO?
Autism Spectrum Disorder			
Developmental problem			
Drug or alcohol problems			
Hearing problems			
Hyperactivity/Attention problems			
Learning problems			
Intellectual Disability			
Psychological problems (please specify type)			
Seizures or epilepsy			

Severe behavior problems			
Speech problems			

Please list changes in parents' occupation since the previous evaluation: _____

Father's occupation: _____ Mother's occupation: _____

Are any other languages currently spoken in the home? _____

By whom are they spoken and how often? _____

What is the child's primary language? _____

Have there been any recent significant stress-producing events? ❒Yes ❒No For whom? ❒Parent ❒Child If yes, explain: _____

_____

_____

B. MEDICAL HISTORY

Is the child now under the care of a doctor(s)? ❒ Yes ❒ No Who? _____ Why? _____

Are immunizations up-to-date? ❒ Yes ❒ No

Is the child in pain? ❒ Yes ❒ No If yes, please explain: _____

Is the child taking medication? ❒ Yes ❒ No Type(s)? _____ Why? _____

Is the child taking herbs or other supplements? ❒ Yes ❒ No Type(s)? _____ Why? _____

Do you think your child's hearing is normal? ❒ Yes ❒ No Has child's hearing ever been tested? ❒Yes ❒ No

If so, when? _____ Where? _____ Results? _____

Do you think your child's vision is normal? ❒ Yes ❒ No Has child's vision ever been tested? ❒Yes ❒ No

If so, when? _____ Where? _____ Results? _____

Does your child wear glasses? ❒ Yes ❒ No

At what age did the following occur? Please explain.

	AGE	EXPLAIN		AGE	EXPLAIN
Adenoidectomy			Eye Problems		
Allergies			Heart Problems		
Asthma			High Fevers		
Blood Disease			Meningitis		
Chronic Colds			Muscle Disorder		
Dental Problems			Nerve Disorder		
Diabetes			Seizures		
Ear Infections			Tonsillectomy		
Ear Tubes			Other		

Describe any other serious illnesses, injuries, physical problems, hospitalizations not mentioned above:

_____

_____

_____

_____

C. DEVELOPMENTAL HISTORY

Please list changes in development or functioning since previous evaluation:

_____

_____

_____

_____

How much of the child's speech do you understand? ❒ 0% ❒ 10% ❒ 25% ❒ 50% ❒ 75% ❒ 100% ❒ Too young to talk

Has your child been diagnosed with any of the following since last evaluation?

✓		BY WHOM	WHEN	DO YOU AGREE?	
				Yes	No
	Autism				
	Cerebral Palsy				
	Developmental Syndrome				
	Genetic Disorder				
	Fine Motor Problem				
	Gross Motor Problem				
	Head Injury				
	Hearing Loss				
	Learning Problem				
	Intellectual Disability				
	Neurological Problem				
	Seizures/Epilepsy				
	Speech and/or Language Problem				
	Visual Impairment				
	Other (specify)				

Mark any evaluations or therapy received. Mark C for current or P for past.

____ Speech-Language ____ Occupational ____ Behavioral ____ Psychological
____ Physical ____ Hearing ____ Counseling ____ Nutritional
____ Parent Training ____ Educational ____ Developmental

Describe results: _____

_____

_____

_____

D. EDUCATIONAL HISTORY

Current school placement: _____ Grade: _____
❒ Regular Education ❒ Special Education ❒ In-home Program

Does your child have any IEP or 504 Accommodations Plan? ❒ Yes ❒ No If yes, under what category? _____

Therapy/services received in school?
❒ Speech/language ❒ Occupational therapy ❒ Physical therapy ❒ Adaptive PE ❒ Resource Room

Does the child remember homework instructions? _____

Does the child follow directions in school? _____

Does the child retain information taught? _____

What is your impression of the child's learning abilities: _____

Are there behavioral concerns in school? _____

What would you like to accomplish for your child through this re-assessment process? _____

_____

_____

_____

_____

_____