Kaiser Permanente Hayward Medical Offices

Developmental Pediatrics

27303 Sleepy Hollow Ave. S.

Hayward, CA 94545

Fax: 510-784-4483

Dear Parent (or Caregiver),

Welcome to Developmental and Behavioral Pediatrics at Kaiser Hayward!

**Why you are receiving this letter:**

Your child has been referred for a developmental pediatrics evaluation because you or your physician have expressed some concerns about your child’s progress in one or more areas of development, such as speech and language, walking and motor skills, or behavior.

**What will happen next?**

If you haven’t already heard from us, someone from our department will be calling soon to talk to you and/or schedule an appointment. You can also call our clinic at 510-784-4482 to set up an appointment.

**What do I need to do before the appointment?**

Background information greatly increases the developmental pediatrician’s ability to assess your child. Please send or fax the following forms prior to your appointment:

1. Developmental Pediatrics Intake Questionnaire (included in this packet)
2. Copies of any initial evaluations completed by early intervention, Regional Center, or non-Kaiser therapists or providers regarding your child’s development or behavior, such as speech/language therapists, developmental pediatrics, psychology, and occupational therapy.
3. **For children 3 and up**: Please provide us with the following: For students with an IEP – your child’s most recent IEP and all evaluations done over the last 3 years (such as speech/language, school psychology, resource specialist, and occupational therapy), as applicable. For students in general education, please provide your child’s last 3 years of report cards, as applicable, as well as SST (Student Study Team) notes, if your child has had any SST meetings.

**What should I expect at the appointment?**

The developmental evaluation will be done by a developmental pediatrician who specializes in problems relating to the development, learning, and behavior of children.

For more information about the providers who may be seeing your child, you can visit their "Homepage:"

Dr. Jean Sakimura: [www.kp.org/mydoctor/jeansakimura](http://www.kp.org/mydoctor/jeansakimura)

There are different types of appointments.

For **telephone appointments**, your provider will call to discuss your concerns regarding your child and to gather history. If you have turned in the records above, they may also discuss their impressions based on the records they have received. These appointments are usually 30-60 min.

**Video visits** are similar to the above. If you have a video visit appointment scheduled, you will receive additional information about how to join the visit from our office. These appointments are also usually 30-60 min.

For **in person visits**, your provider or a staff member will bring you from the waiting room to the room where the evaluation will take place. Staff may take your child’s height, weight, head circumference and blood pressure. The developmental pediatrician will discuss your concerns regarding your child, gather additional history, and review their findings from any records they received. They may also complete developmental testing with your child when and if appropriate. Your developmental pediatrician may also do a physical exam on your child if needed. They will discuss their impression and recommendations with you at the end of the appointment. These appointments generally last 60-90 minutes. There will be toys for younger children to play with. It may be helpful to bring snacks and a drink if you think your child will need them. For children who are still taking naps, try to avoid scheduling the appointment during your child’s nap time.

Thank you for your time and for helping us to provide the best care for your family. We look forward to meeting you and your child! If you have any questions before the appointment, please contact Norma Guzman at 510-784-4482.

Sincerely,

Developmental-Behavioral Pediatrics

Kaiser Hayward

Phone: 510-784-4482

**DEVELOPMENTAL PEDIATRICS EVALUATION INTAKE FORM**

To be completed by parent or legal guardian

Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| CHILD’S NAME  | MEDICAL RECORD #  | BIRTH DATE: AGE:  | SEX: M F  |
| WHAT DOES YOUR CHILD LIKE TO BE CALLED? | ADDRESS: STREET |
| WHO REFERRED YOU TO THE CLINIC?  | CITY  | ZIP CODE |
| WHICH LANGUAGES ARE SPOKEN AT HOME? □ English □ Spanish □ Other:  | CHILD’S PRIMARY LANGUAGE:  |
| NAME OF PERSON COMPLETING FORM  | LEGAL GUARDIAN?  YES  NO  | RELATIONSHIP TO CHILD  |
| PARENT’S NAME / LEGAL GUARDIAN:  Biological Adoptive Step-parent | OCCUPATION  | PREFERRED NUMBER:  |
| AGE: | SCHOOL LEVEL COMPLETED:  | ETHNIC BACKGROUND (OPTIONAL):  |
| PARENT’S NAME / LEGAL GUARDIAN:  Biological Adoptive Step-parent | OCCUPATION  | PREFERRED NUMBER:  |
| AGE: | SCHOOL LEVEL COMPLETED: | ETHNIC BACKGROUND (OPTIONAL):  |
| PARENTS’ MARITAL STATUS (CHECK ONE)  | IF DIVORCED, BRIEFLY DESCRIBE CUSTODY  |
| MARRIED DIVORCED SEPARATED LIVING TOGETHER SINGLE PARENT  | ARRANGEMENTS:  |
| NAMES OF OTHERS IN THE HOME (If two homes, please indicate who lives with your child in each home)   | AGE   | RELATIONSHIP TO CHILD/TEEN (BIO SIBLING, STEP-SIBLING, GRAND PARENT, ETC.)  |
| NAME   |   |   |
| NAME   |   |   |
| NAME   |   |   |
| NAME  PLEASE ADD ANY ADDITIONAL NAMES ON THE BACK OF THIS FORM.  |   |   |

What are your primary concerns in coming to this clinic?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PRENATAL AND BIRTH

|  |
| --- |
| Is your child adopted?  Yes  No In foster care?  Yes  No If Yes, from what age? \_\_\_\_\_\_ |
| Mother’s age during pregnancy: | Prenatal care received?  Yes  No  | Previous pregnancies?  No  Yes: If yes, number of pregnancies \_\_\_\_ Number of miscarriages (if any): \_\_\_\_\_ |
| Were any medications or other methods used to assist with becoming pregnant?  Yes  No  |
| List any prescription medications used during pregnancy:  |
| Did the mother use any of the following while pregnant? Tobacco Alcohol Marijuana Methamphetamines Cocaine/Crack Heroin Methadone Other (specify): \_\_\_\_\_\_\_\_ |
| Were there any problems during pregnancy or delivery?  No  Yes (please explain):  |
| Full term?  Yes  No  | Birth weight: | Length:  | Head Circumference:  |
| If premature, how early? \_\_\_\_\_\_\_ | If overdue, how late? \_\_\_\_\_\_ | Delivery:  Vaginal  C-section  |
| Did your child need any special care after delivery?  No  Yes (please explain): |
| Were there any health problems (feeding difficulties, poor weight gain, etc.) during your child’s infancy?  No  Yes (please explain):  |

# DEVELOPMENTAL HISTORY:

|  |
| --- |
| Age of first developmental concern: \_\_\_\_\_ months |
| Please note the age at which your child first did each of the following (write N/A if he/she does not do this yet): Sat independently: \_\_\_\_\_\_\_ Walked 10 steps: \_\_\_\_\_\_\_Said first word (other than mama/dada): \_\_\_\_\_\_\_ Put two words together (e.g. “my ball”)\_\_\_\_\_\_\_Toilet trained: Bladder \_\_\_\_\_\_\_\_ Bowel \_\_\_\_\_\_\_\_ Feeds self with utensils (fork, spoon) \_\_\_\_\_\_\_ |
| Give an example of something your child might say:  |
| How does your child let you know what he/she needs? |
| Do you have concerns that your child’s ability to think or learn is delayed?  No  Yes: Please specify: How old does your child seem to act to you? \_\_\_\_\_ |
| Was any part of your child’s large muscle development (gross motor) slow (e.g. sitting, walking, skipping, riding bicycle, etc.)?  No  Yes: Please specify:  |
| Was any part of your child’s small muscle development (fine motor) slow (e.g. drawing, writing, cutting, eating with utensils)?  No  Yes: Please specify:  |
| Do you think your child’s self-help skills (i.e. dressing, toileting, bathing, etc.) are age-appropriate?  Yes No: Please explain:  |
| Has your child ever lost any previously acquired and well-established language, motor, self-help, or social skills?  No  Yes - What age? \_\_\_\_ years. Please describe: |
| Please list any past evaluations through Early Intervention, Regional Center, Developmental Pediatrics, etc.:  |

**MEDICAL HISTORY**

Please indicate if your child has had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Concern | Past | Current | Please explain |
| Vision problemsDate of last vision exam: \_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_ | □ | □ |  |
| Ear problems (ear infections, hearing problems, etc.)Date of last hearing exam: \_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_ | □ | □ |  |
| Nose and Throat problems | □ | □ |  |
| Heart conditions | □ | □ |  |
| Lung conditions (asthma or other problems) | □ | □ |  |
| Gastrointestinal problems (vomiting, reflux, diarrhea, constipation, stomach pain, etc.) | □ | □ |  |
| Kidney, bladder or urine problems (daytime/ nighttime bedwetting, urinary tract infections, etc.) | □ | □ |  |
| Skin conditions or birth marks | □ | □ |  |
| Endocrine or hormone problems | □ | □ |  |
| Growth problems (short stature, overweight/underweight, etc.) | □ | □ |  |
| Neurologic problems (headaches, seizures, staring spells, etc.) | □ | □ |  |
| Auto-immune Disorders (lupus, multiple sclerosis, etc.) | □ | □ |  |
| Allergies (food, medicine, environmental, etc.) | □ | □ |  |
| Twitches or jerks of head or arm(s) (not done on purpose): | □ | □ |  |
| Limited diet (picky eater): | □ | □ |  |
| Eating non-food items (Pica): | □ | □ |  |
| Feeding difficulties (e.g., choking, gagging, food refusal, etc.)  | □ | □ |  |
| Sleep problems (falling to sleep, staying asleep, snoring, difficulty breathing at night, etc.) | □ | □ |  |
| Other medical condition or treatment not mentioned above. | □ | □ |  |

|  |
| --- |
| Has your child ever been given any of the following diagnoses?  |
| Learning disability | ADHD | Autism/Asperger/PDD | Speech/Language disorder |
| Epilepsy | Sensory integration | Motor delay | Cerebral Palsy |
| Fragile X | Tourette / tics | Developmental Delay | Behavior/emotional disorder |
| Mental Retardation/Intellectual Disability | Genetic Syndrome | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Has your child had any illnesses or accidents resulting in hospitalization or Emergency Room visits?  No  Yes (please explain): |
| Please list Medications your child is currently taking: |
| Please list past medications your child has taken in the past: |
| Please list vitamins, supplements, special diets, or other complementary/ alternative treatments your child is receiving: |

# MEDICAL HISTORY CONTINUED…

**Please indicate whether your child has ever had any of the following tests:**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Array CGH (microarray) or Karyotype | □ | □ |
| Fragile X | □ | □ |
| Testing for Rett Syndrome (MECP2) | □ | □ |
| MRI of the brain | □ | □ |
| EEG (electroencephalogram) | □ | □ |
| Sleep Study | □ | □ |
| Audiology (Hearing) Testing | □ | □ |
| Other, specify:  | □ | □ |

**My child has sleep problems:**  No  Yes – If Yes, please complete the following questions:

|  |
| --- |
| CHILD’S SLEEP HABITS  |
|  | **Yes** | **No** |
| Child has difficulty falling to sleep. | □ | □ |
| Child has difficulty staying asleep (e.g. frequent nighttime awakenings). | □ | □ |
| Child has restless sleep/ excessive movements of arms and legs. | □ | □ |
| Child is afraid of sleeping alone or sleeping in his/her own bed. | □ | □ |
| Child has snoring, gasping, or stops breathing during sleep.  | □ | □ |
| Child is usually tired or sleepy during the day. | □ | □ |
| Child has frequent nightmares or night terrors. | □ | □ |
| Child sleepwalks or talks during sleep. | □ | □ |
| Child has teeth grinding at night.  | □ | □ |
| Child sleeps in unusual positions (neck hyperextended, sleeping on belly with buttocks up in the air, etc.) | □ | □ |
| Child’s usual amount of sleep at night = \_\_\_ hours, \_\_\_minutes. | Child’s usual amount of sleep during day/ naps = \_\_\_ hours, \_\_\_minutes. |

Please note if any of the following are a problem or concern for your child now**, more than for other children his/ her age (Check all that apply)**.

|  |  |  |  |
| --- | --- | --- | --- |
| * Impulsive/Overactive
 | * Destructive
 | * Unable to separate from parent
 | * More interested in things than in people
 |
| * Short attention span/Distractible
 | * Aggressive
 | * Sad or Depressed
 | * Rocking/spinning/hand flapping
 |
| * Daydreaming
 | * Wetting pants/bed
 | * Suicidal thoughts
 | * Overreacts when faced with a problem
 |
| * Classroom disruption
 | * Bowel accidents
 | * Eats or Mouths non-food items
 | * Requires a lot of parental attention
 |
| * Is easily over stimulated in play
 | * Poor eye-contact
 | * Psychiatric/emotional problems
 | * Self-injurious (head bangs, bites/hits self)
 |
| * Easily frustrated
 | * Low self-esteem
 | * Drug/Alcohol use
 | * Difficulty making or keeping friends
 |
| * Doesn’t follow directions
 | * Isolated/withdrawn
 | * Sexualized behavior
 | * Need for sameness
 |
| * Oppositional/Defiant
 | * Excessive worry/fears
 | * Obsessions or compulsions
 | * Sensitive to noises/ lights/ textures, etc.
 |

If you checked any items above, or if you have any other concerns for your child, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIOLOGICAL FAMILY HISTORY**

Please note who, if any, of the child’s biological relatives have had these conditions (“blood related” family members only; i.e. biological parents, sibling, aunts, uncles, grandparents)

|  |  |
| --- | --- |
|  Conditions:  | Relative(s) who displayed the condition  |
|  Autism Spectrum Disorder |  |
|  ADHD  |   |
|  Learning disabilities or intellectual disability |   |
|  School failure (please explain) |   |
|  Developmental delays (speech delay, delayed walking, etc.) |   |
|  Schizophrenia or psychosis  |   |
|  Depression  |   |
|  Bipolar Disorder |  |
|  Anxiety or OCD  |   |
|  Tics or Tourette’s Disorder  |   |
|  Seizures  |  |
|  Genetic disorder (Down Syndrome, Tuberous Sclerosis Complex, Fragile X Syndrome, Neurofibromatosis, etc.) |   |
|  Substance abuse (alcohol, drugs, etc.)  |  |
|  Other (Please Specify)   |  |

# EDUCATIONAL/DAYCARE HISTORY

|  |
| --- |
| Regional Center Services:  No Services  Current Services (Please specify in hr/week or hr/ month):   |
| Is your child currently in daycare?  No  Yes (Please explain):   |
| School Performance (check one if applicable): N/A Below grade level  At grade level  Above grade level  Mixed (at/above in some areas, below in others) |

# EDUCATIONAL/DAYCARE HISTORY, CONTINUED

|  |  |
| --- | --- |
| Name of School:  |  School District:  |
| Current Grade:  | Type of Class (mainstream or special education services):  |
| Has your child attended more than one school?  No  Yes (please list):  |
| What concerns, if any, does your child’s current teacher have?  |
| List any evaluations your child has received through school (SST, Speech Evaluation, Psychoeducational evaluation, etc.): |
| Has your child ever had an IEP:  No  Yes. If yes, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| List all services your child CURRENTLY RECEIVES at school and how often (*i.e., Resource support or specialized instruction, aide, speech therapy, occupational therapy, adaptive PE, social skills group, positive behavioral support plan, etc.*).  |
| List any other services your child has RECEIVED IN THE PAST through school. |

**FAMILY CHANGES/ STRESSORS:**

Please describe any major family stressors at the present time, if any?

Please note if there is a history of any of the following (check all that apply):

|  |  |  |
| --- | --- | --- |
| Marital discord/separation/divorce | Parent deployed overseas/out of town for work extensively | Severe sibling/parent illness or death |
| Custody disputes |  Parent legal problems |  Financial problems |  Living away from parent |
|  Birth/Adoption of another child |  Parent alcohol/ drug use |  Parent job loss |  Witness physical violence  |
|  Involved in juvenile court |  Parent emotionally/mentally ill |  Other significant trauma/negative event |

If yes to any of the above, please describe the circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate what contact, if any, has occurred with Child Protective Services or the legal system and explain:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD and FAMILY STRENGTHS:**

What does your child like to do for fun? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list some things that your child does well and/or qualities in your child that you admire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your family strengths and supports (e.g. friends, spiritual and cultural considerations): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THANK YOU!!**