DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis. Please complete these forms as best you can.

Today's Date: _____

Child's Name: _____ DOB: _____ Age: _____

Person Completing Form Relationship to Child

Mother's Name Home Phone Work Phone

Address

Father's Name Home Phone Work Phone

Address

Is this your _____biological _____adopted _____step _____foster _____other child

If adopted, how old was the child when he/she was adopted _____

Are you the child's legal guardian: _____yes _____no
If no, please explain:

Name of Guardian Home Phone Work Phone

Address

Referred by Phone

Primary Care Physician Phone

Address

Have you notified your physician of this appointment? _____yes _____no

MOTHER'S MARITAL STATUS

Married _____yes _____no

How many times has she been married _____

How long has she been married to present husband _____

Separated _____yes _____no

How long did she live with spouse before separating _____

How long has she been separated _____

Divorced _____ yes _____no

How long was she married to last spouse _____

How long has she been divorced _____

FATHER'S MARITAL STATUS

Married _____yes _____no

How many times has he been married _____

How long has he been married to present husband _____

Separated _____yes _____no

How long did he live with spouse before separating _____

How long has he been separated _____

Divorced _____ yes _____no

How long was he married to last spouse _____

How long has he been divorced _____

PEOPLE LIVING IN HOME WITH PATIENT

Name	Age	Birth Date	Relationship to Patient

Continue:

Has your child been seen by any of the professionals listed below for emotional/behavioral problems such as depression, anxiety, school refusal, ADHD, etc? Please check all that apply

_____ School Counselor

_____ Physician

_____ Psychiatrist

_____ Psychologist

_____ Social Worker

_____ LPC

Please list the type of treatment received

OUTPATIENT TREATMENT: **Duration of Treatment**

Physician/therapist Address From To

INPATIENT TREATMENT:

Facility/Hospital Name Address Treating M.D. Duration

What are your concerns about your child? _____

Why are you seeking professional help at this time? _____

Current Medications your child is taking, including vitamins _____

_____

_____

_____

CHILD'S EDUCATIONAL PLACEMENT

Schools attended and grades completed. Most recent first.

_____

_____

_____

_____

Check all the official school classifications that apply to your child:

_____ Learning Disabled

_____ Visually Impaired

_____ Emotionally Disturbed

_____ Hearing Impaired

_____ Mentally Retarded/Intellectually Limited

_____ Physically Handicapped

Resource Teacher's Name _____

School Name _____

Psychologist/Counselor's Name _____

The names, address, phone number of any other person involved in your child's education that you feel we should contact:

Did your child experience any problems in preschool _____ yes _____ no

If yes, please describe _____

Has your child repeated any grades _____ yes _____ no

If yes, which grades and what was the reason for repeating that particular grade _____

Did your child fail any subjects _____ yes _____ no

If yes, which ones and why _____

_____

Does your child currently receive special education services _____ yes _____no

If yes, specify type: (self-contained class, resource room, reading or math lab….)

Frequency of attendance in special classes (full- time placement, once a day-30 min sessions)

Please list any other school problems _____

Does your child have problems interacting with peers _____ yes _____ no
If yes, specify

CHILD'S MEDICAL HISTORY

Please list Medical Illness _____

_____

_____

List any allergies to medications _____

_____

_____

Your child's current health _____ poor _____ fair _____ good _____ excellent

Is your child, in any way, physically ill at this time _____ yes _____ no

CHILDHOOD DISEASES

Check all that apply. Please describe the condition, type of treatment received and if your child continues to receive treatment for the condition.

_____ Asthma _____ Anemia

_____ Lead poisoning _____ Meningitis

_____ Encephalitis _____ Seizures

_____ Hydrocephalus _____ Cerebral Palsy

_____ Mental Retardation _____ Heart problems

_____ Vision Difficulties _____ Hearing Difficulties

_____ Intellectual Disability (MR)

Any other handicapping conditions or special health considerations _____ yes _____ no
If yes, please explain

List any Emergency Room visits Age Outcome

List any surgeries your child has had Age Outcome

List other hospitalizations _____

List any head injuries and if there was any loss of consciousness. Age

Has your child experienced any seizures _____ yes _____ no

Age when seizure occurred _____

Please describe the seizure and the treatment _____

_____

_____

What is the highest fever your child has had _____

What was the nature of the illness associated with this fever _____

_____

Was your child ever in a coma _____ yes _____ no

If yes, please explain _____

_____

_____

Has your child ever suffered from any type of poisoning _____ yes _____ no

If yes, please explain _____

_____

_____

MOTHER'S HISTORY

Name _____ DOB _____ Age _____

Birth Place _____ Religion _____

Highest Grade Completed _____ Highest Degree _____

Were you ever in any type of special education class _____yes _____ no

If yes, please explain _____

Have you ever experienced difficulties with reading _____ yes _____ no

If yes, please explain _____

Have you experienced difficulties with writing _____ yes _____ no

If yes, please explain _____

Have you experienced difficulties with math _____ yes _____ no

If yes, please explain _____

Generally, what sort of student were you grade wise

A/B B/C C/D D/F

Did you repeat any grades _____ yes _____ no

If yes, which grades and explain the reason for repeating the grade _____

Did you fail any subjects _____ yes _____ no

If yes, which subjects _____

Any behavioral problems _____ yes _____ no

If yes, please explain _____

Have you ever been told or thought yourself that you might have an attention deficit or be

Hyperactive _____ yes _____ no

Any medical problems _____ yes _____ no

Please specify _____

Current occupation _____

Place of Employment _____

During which years of child's life have you worked _____

Previous work history _____

FATHER'S HISTORY

Name _____ DOB _____ Age _____

Birth Place _____ Religion _____

Highest Grade Completed _____ Highest Degree _____

Were you ever in any type of special education class _____yes _____ no

If yes, please explain _____

Have you ever experienced difficulties with reading _____ yes _____ no

If yes, please explain _____

Have you experienced difficulties with writing _____ yes _____ no

If yes, please explain _____

Have you experienced difficulties with math _____ yes _____ no

If yes, please explain _____

Generally, what sort of student were you grade wise

A/B B/C C/D D/F

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Any medical problems _____ yes _____ no

Please specify _____

Current occupation _____

Place of Employment _____

During which years of child's life have you worked _____

Previous work history _____

FAMILY PSYCHIATRIC AND MEDICAL HISTORY

Specify any family members, even distant ones, who suffer from mental health problems and list any medical problems your aware of in your family.

	Relationship to Patient	Medications (specify)	Hospitalization (specify)
Depression			
Bi-polar Disorder			
Anxiety Disorder			
Schizophrenia			
Eating Disorder (Anorexia/Bulimia)			
Learning Disorder			
Substance Abuse alcohol/drug			
ADHD			
Suicide attempt Or completion			
OCD/Obsessive Compulsive Disorder			
Speech Problems			

	Relationship to Patient	Medications (specify)	Hospitalization (specify)
Heart Problems			
Thyroid Problems			
Tourettes tic Disorder			
Violent Problems			
Obesity			
Epilepsy			
Diabetes			
High Cholesterol			
Legal Problems			
Other Please Specify			

CHILD'S DEVELOPMENTAL HISTORY

PREGNANCY

Mom's age when pregnant with patient _____

Planned pregnancy _____ yes _____ no

Duration in months or weeks if know _____

Were any medications used during pregnancy _____ yes _____ no

If yes, please specify _____

Did you smoke cigarettes during pregnancy _____ yes _____ no

Did you drink alcohol during pregnancy _____ yes _____ no

Did you use any drugs during your pregnancy _____ yes _____ no

If yes, what kind of drugs and how much _____

Pregnancy Complications (check all that apply)

_____ Bleeding

_____ Infections

_____ Kidney Problems

_____ High Blood Pressure

_____ Swelling

_____ Excessive Vomiting

_____ Weight Loss

_____ Diabetes

_____ Excessive Weight Gain

_____ Fever

_____ Toxemia
Other problems, please explain _____

DELIVERY

Type of Delivery _____ Spontaneous _____ Induced

If induced, please specify reason _____

Type of Birth _____ Normal _____ Breech _____ Cesarean Section

Duration of Labor (hours) _____

Check all that apply _____ Forceps used _____ Hemorrhage/excessive bleeding

_____ Multiple Birth _____ Baby born in some type of danger

Specify Danger (cord around neck, heart rate, etc.) _____

_____

Anesthesia: _____ None _____ General _____ Local (epidural/spinal)

_____ Muscle relaxant

Were there any problems with labor and delivery _____ yes _____ no

If yes, please explain _____

PERINATAL HISTORY

Baby's weight at birth _____

APCAR score, if known at birth _____, At 5 minutes _____

Number of days baby stayed in the hospital following birth _____ days

Number of days mother stayed in the hospital following baby's birth _____days

List any birth defects _____

_____

_____

Describe any other problems your child had when he/she was a newborn _____

_____

_____

INFANCY AND EARLY CHILDHOOD

Check all that apply

_____ Colicky	_____ Restlessness	_____ Active
_____ Head Banging	_____ Feeding Problems	_____ Accident prone
_____ Sleeping Problems	_____ Did not enjoy cuddling	_____ Uncoordinated

Child's approximate age when he/she began:
Walking (months) _____

Talking (single words-years) _____

Short Sentences (2 + words-years _____

Toilet Training Daytime _____ (years) Nighttime _____ (years)

Does your child continue to have wetting accidents (Day/Night) _____ yes _____ no

Does your child continue to have soiling accidents (Day/Night) _____ yes _____ no

Overall, do you feel your child developed at a _____ slow _____ normal _____rapid rate

List any stressful or traumatic events in your child's life, which may have affected his/her developments and ability to function. (birth of a sibling, death in the family, divorce, illnesses, frequent school changes, witnessing a trauma)

_____

_____

_____

_____

Please use this space and any additional sheets for any additional information/comments you with to share with us about your child or family.

_____

_____

_____

_____

_____