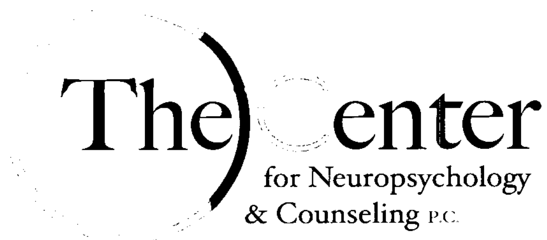


## Developmental Questionnaire

The following questions are asked to help us better understand your child. This information is very important in making an accurate diagnosis and providing recommendations. Please read the questions carefully and answer as fully as possible. We will have the opportunity to discuss these questions in detail at the time of your child's appointment. Thank you.

PLEASE PRINT

CHILD'S NAME ________________________ TODAY'S DATE ___________

GENDER ____ M ____ F BIRTHDATE __________________ AGE ________

SCHOOL ____________________________________ GRADE ____________

CHILD'S HOME ADDRESS ______________________________________

______________________________________

______________________________________

HOME PHONE___________________ OTHER PHONE_________________

EMAIL ADDRESS ________________________________________________

PERSON COMPLETING FORM _____________________________________

RELATIONSHIP TO PATIENT ______________________________________

ARE YOU THE CHILD'S LEGAL GUARDIAN? YES NO

IF NO, PLEASE GIVE NAME OF LEGAL GUARDIAN ___________________

REFERRED BY: __________________________________________________

ADDRESS: ______________________________________________________

______________________________________________________

PHONE: _________________________ FAX:___________________

What are your concerns about this child? What do you feel his/her difficulties/problems are at this time?

______________________________________________________________________

______________________________________________________________________

2/3/11 10:39 AM

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What strategies have you tried to help? ________________________________________

________________________________________________________________________

________________________________________________________________________

What questions do you have that you hope this evaluation will answer? ____________

________________________________________________________________________

________________________________________________________________________

Has your child ever been evaluated by a health care or educational professional?
YES_____ NO_____ If yes, please explain: (**Please provide a copy of all reports**): ______

________________________________________________________________________

________________________________________________________________________

______

Has a psychologist or other professional ever diagnosed this child? YES_____ NO_____ If yes, please explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What treatment, if any has your child received for the above problems? ____________

________________________________________________________________________

________________________________________________________________________

PLEASE LIST ANY PROFESSIONALS WHO HAVE SEEN THE CHILD/FAMILY:

| Name | Date(s) seen | Procedure (testing, therapy, MRI) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

PARENTS' MARITAL STATUS______ IF MARRIED, HOW LONG?________

If divorced, when was the divorce final? ______________

Is there a written custody agreement? ________________

If so, who has primary physical custody and what are the arrangements? _______________

___

___

Does this child have any step-parents?

___

___

___

PLEASE LIST EVERYONE IN THE FAMILY AND OTHERS LIVING IN THE HOME:

| NAME | AGE | BIRTHDATE | RELATIONSHIP TO CHILD |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Mother:**

Name: ___

Address (if different from child): ___

Phone (if different from child):HOME _______________WORK _______________

Date of Birth: _______________ Age: _____________ Highest Grade Completed ________

Occupation/Profession: ___

Current place of employment: ___

Were you ever in any type of special education class? YES___ NO___ If yes, please explain: ___

___

Please indicate if you or any member of ***your birth family (Mother's family)*** has had any of the following:

| Condition | You | Your Mother | Your Father | Your Siblings | Other (please specify) |
|---|---|---|---|---|---|
| Attention problems | | | | | |
| Math difficulties | | | | | |
| Discipline problems | | | | | |
| Failing subjects | | | | | |
| Failing grades | | | | | |
| Reading difficulties | | | | | |
| Writing difficulties | | | | | |
| Social situations | | | | | |

**Father**:
Name: ______________________________________________

Address (if different from child):______________________________

Telephone (if different from child): HOME _____________ WORK __________

Birthdate: ____________ Age: _____ Highest grade completed _____________

Occupation/Profession: ______________________________________

Current place of employment: __________________________________

Were you ever in any type of special education class? YES___ NO___ If yes, please explain: ____________________________________________

______________________________________________________

Please indicate if you or any member of ***your birth family (Father's family)*** has had any of the following:

| Condition | You | Your Mother | Your Father | Your Siblings | Other (please specify) |
|---|---|---|---|---|---|
| Attention problems | | | | | |
| Math difficulties | | | | | |
| Reading difficulties | | | | | |
| Writing difficulties | | | | | |
| Discipline problems | | | | | |
| Failing subjects | | | | | |
| Failing grades | | | | | |
| Social problems | | | | | |

## PRENATAL HISTORY

Pregnancy Complications: (Please place an "X" for those that apply to your pregnancy with this child):

| X | Condition | X | Condition | X | Condition |
|---|---|---|---|---|---|
| | Anemia | | High blood pressure | | Serious injury |
| | Confined to bed | | High fever | | Special diet |
| | Diabetes | | Hospitalizations | | Surgery |
| | Drug/alcohol use/abuse | | Incompatible Rh factor | | Toxemia |
| | Depression or Anxiety | | Infections | | Unusual worries/stress |
| | Excess weight gain | | Morning sickness | | Weight loss |
| | Excessive bleeding | | Rubella | | Other ________ |
| | Excessive vomiting | | Seizure | | |

## PERINATAL HISTORY

DELIVERY:

Check all that apply to describe the birth of this child:

_____spontaneous delivery
_____breech presentation (feet 1st)
_____normal presentation
_____induced delivery
_____premature delivery (_____ weeks)
_____late delivery (_____weeks)
_____Cesarean section (C-section)
_____forceps used
_____vacuum used

_____local anesthesia (epidural/spinal)
_____muscle relaxant
_____pain medication
_____general anesthesia
_____use of Pitocin
_____fetal distress
_____hemorrhage
_____multiple births (e.g. twins)
_____duration of labor (________hours)

Birth Weight: __________ Length: _________

APGAR Scores: One min._____ Five min._____

Place an "X" for any of those that described your child shortly after birth:

___jaundiced
___ use of incubator
___ rashes
___ problems eating/digestion
___ Other ________________________________

___ very quiet
___ very active
___ breathing problems
___ baby given oxygen

___ blood transfusions
___ problems sucking
___ use of heart monitor
___ Failure to Thrive

Were there any problems with labor and delivery? YES___ NO____ If yes, please explain: _

_______________________________________________________________________________

_______________________________________________________________________________

Please report any other problems or comments regarding this child when he/she was a newborn: _______________________________________________________________

_______________________________________________________________________________

**INFANCY AND EARLY CHILDHOOD**: (Place an "X" for those items that described your child)

___ Colic
___ Sleeping problems
___ Active
___ Uncoordinated
___ Unclear speech
___ Other specify: ______________________________
___ Head-banging
___ Irritability
___ Did not enjoy cuddling
___ Digestive problems
___ Difficulty separating
___ Feeding problems
___ Restless
___ Accident-prone
___ Chronic infections
___ Digestive problems

**DEVELOPMENTAL MILESTONES**: (Please provide the **approximate age** for each milestone)

Crawled: ____________
First steps: ___________
Ran: ________________
Rode two-wheeler ___________
First syllables ("ma ma"): ____________
First words: _____________
2-3 Word Phrases: _____________
Complete Sentences: ______________

Age Toilet Trained (Day): _____________ Toilet Trained (Night): _____________

Does your child have wetting or soiling accidents? YES_____ NO_____

Is your child right-handed, left-handed or mixed? _____________

Would you describe your child as coordinated/athletic? YES_____ NO_____ Please explain: ________________________________________________________________

________________________________________________________________________

Has your child ever:

_______Had a stutter
_______Grind his/her teeth
_______Had tic/nervous twitches
_______Had a speech evaluation?
_______Rocked back and forth
_______Stare off/go blank

Please describe any other problems or comments regarding your child's infancy and early childhood development: ______________________________________________

________________________________________________________________________

________________________________________________________________________

Describe the best things about your child: ______________________________________

________________________________________________________________________

________________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Describe your child socially (friends, fights, dating, popularity, participation, etc.): ________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Does your child or has your child ever:

Had problems relating to playmates, classmates or peers? ______________________

Fight frequently with peers? ______________________________________________

Prefers playing with younger children? _________________________________

Had difficulty making friends? ____________________________________________

Prefer to play alone? ____________________________________________________

Are there children in the neighborhood with whom the child could play? ______________

What role does the child usually take in social settings (leader, follower, etc.)? ___________

What activities does your child enjoy/participate in? (sports, hobbies, etc.) ______________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Do you suspect your child to be using or abusing drugs or alcohol? If yes, please explain. ___

______________________________________________________________________

______________________________________________________________________

Has your child had any legal problems? (contact with juvenile justice, arrests, citations, etc.)

______________________________________________________________________

______________________________________________________________________

Is your child sexually active? YES___ NO___ Does your child smoke? YES___ NO___

## PRESENT MEDICAL STATUS

Current Health: ______________________ (Please rate poor, fair, good, excellent, etc.)

Is your child in any way physically ill at this time? YES__ NO__ If yes, please explain and specify if your child is currently being treated for this illness: ______________________

______________________________________________________________________

Does your child wear glasses or contacts? ______________________________________

Date of last eye exam: ______________________

Does your child have any difficulty hearing? ______________________________
Date of last hearing exam: __________________

How would you describe your child's sleep? ______________________________
How many hours of sleep per night does your child typically get? __________________

How would you describe your child's appetite? ______________________________

Please check all that apply to your child:

_______ Mid-night awakenings
_______ Difficulty falling asleep
_______ Difficulty waking up
_______ Snores
_______ Nightmares/night terrors
_______ Recent weight gain or loss
_______ Low variety of foods in diet
_______ Poor/distorted body image

Is your child currently or previously involved in any type of professional mental health treatment (i.e., therapy, family counseling, etc.)? YES _____ NO_____ If yes, please list:

| Clinic | Date(s) seen | Contact Person | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## MEDICAL HISTORY

Has your child undergone any type of surgery? YES_____ NO_____ If yes, please explain:

______________________________________________________________________

______________________________________________________________________

Has your child suffered any type of head injury? YES___ NO___ If yes, please indicate your child's age, how he/she was injured and whether or not consciousness was lost at the time of the incident: ____________________________________________

______________________________________________________________

Has your child ever experienced convulsions or seizures? YES_____ NO_____ If yes, please indicate the nature of the convulsions and whether or not these occurred with high fevers; please indicate the child's age at the time of the convulsions: ________________

______________________________________________________________

______________________________________________________________

Has your child experienced persistent high fevers? YES____ NO____ If yes, please explain: ______________________________________________________

______________________________________________________________

______

Was your child ever in a car when it was in an accident (even a minor one)? YES_____ NO_____ If yes, please explain: ____________________________________

______________________________________________________________

______________________________________________________________

Does your child suffer from allergies? YES_____ NO_____ If yes, please explain type of allergic reaction and the treatment he/she is receiving, if any: ____________________

______________________________________________________________

______________________________________________________________

Has your child suffered from persistent ear infections? YES__ NO__ If yes, please explain: _

______________________________________________________________

______________________________________________________________

Has your child been hospitalized for any illness not covered thus far? YES_____ NO____
If yes, please explain: _________________________________________________

______________________________________________________________

______________________________________________________________

Please list any medication your child is currently taking:
Medication Dose (e.g. 20mg four times a day) Date Started

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**FAMILY HISTORY**

Place an "X" next to any medical condition your child or any member of your family has had/has.

| X | Condition | X | Condition |
|---|---|---|---|
| | Asthma | | Hydrocephalus |
| | Asperger's Syndrome | | Lead poisoning |
| | Attention Deficit Hyperactivity Disorder | | Learning Disability |
| | Autism/Pervasive Developmental Disorder | | Meningitis |
| | Bipolar Disorder | | Mental retardation |
| | Cerebral palsy | | Migraines |
| | Cystic Fibrosis | | Multiple sclerosis |
| | Diabetes | | Neurological Problems |
| | Drug or Alcohol Use/Abuse | | Seizures |
| | Emotional problems (depression/anxiety) | | Schizophrenia/psychosis |
| | Epilepsy | | Speech/Language Problems |
| | Fragile X Syndrome | | Tourette's Syndrome/Tics |
| | Hearing difficulties | | Vision difficulties |

**EDUCATIONAL HISTORY:**

Name of Current School: ______________________________
Home School District: ______________________________

School Address: ______________________________

______________________________

Grade Placement: ____________

Classroom Type (i.e., regular, LD, resource room, etc.): ____________
Number of students in class: ________

Teacher's Name: ______________________________________________
Principal's Name: _____________________________________________
School Psychologist or Counselor: ________________________________

Has your child ever had an Individual Education Plan (IEP) or Chapter 504 Agreement? YES___ NO___

Under what educational classification? (Autism, Specific Learning Disability, Emotional Disturbance, Mentally Gifted, Hearing Impaired, Speech/Language Impaired, Traumatic Brain Injury, Visually Impaired, Mentally Deficient, Multiple Handicapped) ____________

______________________________________________________________________

______________________________________________________________________

Please list the name(s), addresses and telephone numbers of any other persons involved in your child's education who you feel we should contact:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Did your child attend a preschool program? YES_____ NO_____

Did your child repeat any grades? YES_____ NO_____ If yes, which ones and for what reason(s)? ____________________________________________________________

______________________________________________________________________

Did your child ever skip a grade? If so, which one? ______________________________

Does your child have a history of failing subjects? YES___ NO___ If yes, which ones? ____

______________________________________________________________________

______________________________________________________________________

What are your child's most recent grades?

_____ Reading/English
_____ Math (specify which math______________)
_____ Language Arts
_____ Social Studies
_____ Science
_____ Art
_____ Music
_____ Gym
_____ Other (specify ____________________________)

Does your child currently receive special education services? YES _____ NO_____ If yes, specify <u>type and frequency</u>. ____________________________________________

Does your child have any difficulty with Reading? ________________________________

________________________________________________________________

Does your child have any difficulty with Math? __________________________________

________________________________________________________________

Does your child have any difficulty with Writing? ________________________________

________________________________________________________________

Please list any unusual and/or traumatic event(s) in your child's life which you feel may have impacted upon his or her development (i.e., abuse, birth of a sibling, death in the family, divorce, illnesses, frequent school changes, familial moves, financial problems, anything.) or any other information you feel may be helpful:

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________