Today's Date: _____

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DEVELOPMENTAL QUESTIONNAIRE

Child's Name: _____ Child's Nicknames: _____

Birth Date: _____ Age: _____ Years: _____ Months: _____ Sex: □Male □ Female

Address: _____ (City) _____(State)_____(Zip Code) _____

Who referred your child: _____ Phone:(____)_____ Fax: (___)_____

Pediatrician's name: _____Phone:(____)_____ Fax: (___)_____

Pediatrician's address: _____(City)_____(State_____(Zip Code)_____

Date of last medical check -up _____Health Status:_____Any Allergies ___(No) ___(Yes)

Family Information

Overall how would you describe family relations in your home? _____

_____

Mother			Father		
Name:			Name:		
Date of Birth:			Date of Birth:		
Address:			Address:		
City:	State	Zip:	City:	State:	Zip:
Home Phone:			Home Phone:		
Mobile Phone:			Mobile Phone:		
Email:			Email:		
Occupation:			Occupation:		
Employer:			Employer:		
Education:			Education:		
Religious Identification:			Religious Identification:		
# of Siblings in Your Family:			# of Siblings in Your Family:		
Your Nicknames as a Child:			Your Nicknames as a Child:		
Your Position Among Your Siblings:			Your Position Among Your Siblings:		

About Your Child

Sibling:	Age

What do you see as the nature of the problem your child is now experiencing? _____

_____

Has your child ever attempted suicide or even joked about it? If so, please describe the situations in as much detail as possible. _____

Has your child ever run away? _____ If so, how many times? _____

Please describe the situations in as much detail as possible? _____

Has your child ever been arrested? _____ If so, how many times? _____ please describe the situations in as much detail as possible, indicating what the offenses were and what resulted. _____

Please describe your child's strengths and good qualities? Talk about those aspects of him/ her which are most lovable and which make you most proud._____
How would you describe your child's personality?_____
How do you think your child sees him or herself and how would your child describe his or her personality?_____
_____

If any of the following have been a problem for your child, please check off the item and explain as much as you can.

Behavior	yes	Please Explain	Behavior	yes	Please Explain
Fingernail Biting			Sleep walking		
Frequent nightmares			Temper tantrums		
Soiling pants			Stealing		
Stuttering			Truancy		
Lying			Frequently disobedient		
Strong willed			Excessive fears or worrying		
Cruelty to Animals			Drug use		
Fire starting			Alcohol use		
Easily excitable			Repetitive behaviors		
Needs excessive attention			Running away from home		
Behavior problems at home			Body rocking		
Poor school performance			Bed wetting		
Few friends			Often unhappy		
Trouble getting along with friends			Too sensitive		
Cruelty to friends			Facial tics or vocal		
Thumb sucking			Accident prone		
Arrests			Run away		
Strengths			Personality type		

Medical History

Please indicate any serious injuries, operations, hospitalizations, or illnesses including head injuries, which he/she has had.

Injury or Illness	Dates in Hospital	Location	Physician

Does your child have any chronic illnesses?

Illness	Age at Diagnosis.	Dr.	Medication	Dosage

Medications child takes on a regular basis

Does your child take any other medications? _____ if so, please list them and their Dosages.

Medication:	Dosage Frequency

Current height: _____ Current weight: _____
Does your child have any history of allergies? _____ If so, what are they and how are they treated? _____
_____
Please describe your child's overall health. _____

Visual or perceptual problems? _____
Do child need glasses to read? Yes _____ No ____ Child has poor hearing Yes _____ No ____
Chronic illnesses Yes ____ No ____ Physical abnormalities Yes ____ No ____
If so, please list: _____

Traumatic experiences or circumstances: (Circle all that apply)

Separations, illnesses, parent illnesses, family deaths, miscarriages, operations, reactions to medical and surgical procedures, sexual trauma, sexual assaults, birth of sibling, divorce of parents, parents dating, remarriage of parents, adoption and reaction to it: _____

Has your child ever received any counseling or psychotherapy? _____ if so, please explain the circumstances: _____

_____

Psychotherapy History

Age	Frequency of Sessions	Duration of Treatment	Dr.'s Name	Treated for…

Current School Placement - Please describe the following:

School: _____Teacher: _____
Grade: _____: Phone Number of School: (___) _____-_____; Fax Number of School: (___)_____ -_____
How is your child currently doing in school? _____
What advice do you remember giving your child on the first day of school? _____
Have you or anyone else identified any specific learning problems? _____ if so, please describe them: _____

_____

Have the school principals or teachers ever called you regarding behavior problems of your child at school? _____
If so, what were the circumstances? _____
Is your child currently in any special placement or receiving any special education services? _____
If so, please describe them: _____
Have there been IEP meetings regarding your child? _____ When was the last one? _____

* **If you have a copy of the IEP, please attach it to this family history questionnaire.**

Has your child ever had any educational or psychological testing? ___No __Yes___ Dates:

_____

By Whom? _____

Social History - Please describe the following:

Explain how your child interacts with peers _____
How many friends does the child play with on a regular basis? _____
Activities, sports and games child enjoys _____

Birth and Early Developmental Milestones

Pre-natal - Please describe the following:

Whether pregnancy was wanted or planned, where there any special circumstances or stresses at time of conception:

_____

Pregnancy - Please describe the following:

Quality of biological parents' relationship during pregnancy: _____
Mother's health during pregnancy, morning sickness, vomiting, toxemia or eclampsia, German measles, RH incompatibility, sexually transmitted diseases: _____
Who suggested your child's name? _____
Why did you choose this name? _____
Was your child adopted? _____At what age? _____

If you did adopt this child, please give as much background information about your child's biological family and your adoption process as possible. _____
Birth Weight: ____ Premature: ___Yes___ No/Length of labor: _____C-Section: __Yes___No /Full Term___No___Yes

If there were any complications or problems during your pregnancy, please describe what they were: _____
_____
Baby's physical status at birth _____
Mother's first impressions of baby _____
Father's first impressions of baby _____
Mother's reactions to the labor _____
How was your health during the first few months after your child was born? _____
If your child's mother worked outside the home during your child's first year, what was the work and how long each day was the mother separated from the child? _____
How would you describe your child's sleeping patterns during the first year? _____
How would you describe your child's sleeping patterns now? _____
Was there anything unusual in your child's speech development? _____

***Immediate Post-Natal Period* - Please describe the following:**

Who cared for infant _____
Father's involvement _____
Mother's involvement _____
Extended family help _____

Feeding History

Did you breast or bottle feed or both? _____ If you breast fed, for how long? _____
Did your child have any feeding problems or unusual habits? _____ If so, what were they? _____
_____
Mothers' reaction and attitude toward feeding of infant _____
Colic: ____Yes ____ No - How long did it last? _____
How was your child's colic handled? Please describe: _____
Post-Partum Depression: Did you experience Post-Partum Depression? Yes___ No___ When_____
How long did the symptoms last? _____Did you receive treatment? Yes ___ No ____ Duration of treatment _____
Did you have gestational diabetes: ___Yes___No - Please describe your experience: _____
_____

Toddler ***- Please describe the following:***

How did your child react to new situations and changes in routine? _____
Gastro-intestinal issues _____
Allergies or dietary restrictions _____
Illnesses during first year _____
Noticeable changes after illness _____
Hospitalizations during first year _____ reactions _____
Sleeping Issues _____
Bedtime routines _____
Does child sleep and stay in own room? Yes _____ No _____
Age sat up _____ Age crawled _____ Age walked _____ Age spoke first words _____
What are the first words you remember your child saying? _____
Age spoke in simple sentences _____
Child's reactions to cuddling, being picked up _____
Was infant withdrawn or responsive to parents? _____

Toilet Training History:

Age training started _____ Age training concluded _____
Method of training _____
Emotional Disturbances related to training (retention, soiling, day wetting) _____
Age when dry at night _____ Reactions to toilet training _____
Aggressive behavior _____
Independent behavior, oppositional behavior _____
Passivity, withdrawal _____

Motor development _____
Interaction between child and each parent _____
Temper tantrums and how handled _____
Illnesses _____

***Age Three to Six* - Please describe the following:**

Pre-school separations _____
Thumb sucking, pacifier use _____
Please explain your child's curiosity about his/her body: _____
Daydreaming and fantasy life _____
Fears and phobic reactions _____
Sleeping arrangements _____
Relationships with mother, father, siblings, other children _____
Sexual curiosity and parents' method of responding to questions: _____

***Age Seven to Ten* - Please describe the following:**

Age school began _____ Learning difficulties _____
School problems and adjustment _____
Favorite, disliked, and difficult subjects _____
Relationships with teachers and peers _____
Speech pathology _____
Nature and extent of extra-curricular activities _____
Absenteeism or school refusal _____
Lying _____ Stealing _____
Daydreaming and fantasies _____
Group activities _____ Team sports _____
Sleep disturbances _____
Eating disturbances _____

***Puberty and Adolescence* - Please describe the following:**

Physical development and health _____
Social development and patterns _____
Has your child reached puberty? ___Yes_____No; Please describe your impression of your child's feelings about puberty:
_____
Sexual knowledge – how was it learned _____
Special Interests _____
Relationships with peers of same and opposite sex _____
School and vocational experience_____
Ideals and ambitions _____
Separations for camps and programs _____
Emancipation from home _____
Emotional health– enuresis, temper tantrums, nail biting, sleep walking, stuttering, eating disturbances anorexia, bulimia, over-eating), fears, delinquent behavior or anti-social behavior-lying, cruelty; substance abuse _____
_____
_____
_____
_____

Marriage History

The parents who are raising this child are currently:
Married Separated Divorced How many marital changes have there been? _____

Marital Changes

Changes in Marriages	Age of Your Child at the Time of Change

History of Family Moves

How many moves has your child made? _____

From:	To:	Age of Your Child at the Time:

History of Caretakers and Separations

Please list who were the main caretakers for your child were and at what ages.

Name of the Caretaker	His/her Role in Your Family	Age of Your Child When This Person Started	Age of Your Child When This Person Left

Was there any separation between mother and child that lasted more than several days when your child was under five years old? _____ If so, please list them, give your child's age and the reasons for the separations.

Age of Child	Duration of Separation	Reasons for Separation	Caretaker During Separation

History of Deaths in Your Family

Who are the people in your child's life who have died?
Please include anyone who has been important.

Person's Name:	Relationship to Your Child:	Cause of Death:	Your Child's Age at The Time of Death:

Additional Family Information

Have any of these circumstances been a problem for anyone in your family?

Mother's Family		Father's Family	
Conditions	Relation to Child	Conditions	Relation to Child
Excessive Drinking		Excessive Drinking	
Nervous Breakdown		Nervous Breakdown	
Illegal Drug Use or Addiction		Illegal Drug Use or Addiction	
Autism		Autism	
Alcoholism		Alcoholism	
Physical Abuse		Physical Abuse	
Sexual Abuse		Sexual Abuse	

Psychosis		Psychosis	
Schizophrenia		Schizophrenia	
Bipolar Disorder		Bipolar Disorder	
Depression		Depression	
Gender Issues		Gender Issues	
Incarceration		Incarceration	
Problems in School		Problems in School	
Mental Retardation		Mental Retardation	
Psychiatric Hospitalization		Psychiatric Hospitalization	
Suicide		Suicide	
Incarceration		Incarceration	

Your Family's Educational History

Mother's Family-Grandparent to child?	Father's Family-Grandparent to child?
Your mother's educational level:	Your mother's educational level:
Your father's educational level:	Your father's educational level:
Current Profession:	Current Profession:

Please provide any other information that will help us understand your child and the family better:

Clinician's notes:

Observations about the child

Observations about the child's parents' relationship with child

Parents attitude about treatment for child

Changes in parent-child interaction during course of evaluation

Expectations of parents regarding child's treatment

Degree to which parents are expected to be involved

Clinician's Name: _____ Clinician's Supervision: _____

Clinician's signature: _____ Date: _____