DEVELOPMENTAL HISTORY QUESTIONNAIRE

Date ____________ Name of person completing this form ____________________

Contact telephone number ______________ Email ______________________

Relationship to child __________

Child's name ______________ Date of Birth __________ Grade _____ Sex __

Primary spoken language _______ First language learned ________ R/L handed ____

Address: House ____ Apartment ____ Other ____________

Family Demographics

Mother __________ Living in child's home? _____ Age ___ Primary language _____

Occupation ______________ Highest level of education completed __________

Father __________ Living in child's home? _____ Age ___ Primary language _____

Occupation ______________ Highest level of education completed __________

If parents are separated or divorced, who has custody of the child? ____________

Frequency of contact with the other parent? ______________________

Other adults frequently involved in parenting this child?

Name __________ Age _____ Relationship to child ______________

Occupation ______________ Highest level of education completed __________

Name __________ Age _____ Relationship to child ______________

Occupation ______________ Highest level of education completed __________

How long has the child lived at the current address? __________

How frequently is this child cared for by people other than the primary caretakers (e.g. baby-sitters, day care)? ______________

How does the child respond to other caretakers? ____________________

____

____

Additional siblings

Name	Age	Living in child's home?	Grade or Occupation

How does the child get along with each of the siblings? What types of activities do they do together, and how frequently? ______

______

______

______

How often does the child spend time with other relatives (e.g. grandparents, cousins)? Does the child enjoy this? ______

______

Please circle the 'C' next to any problem below that the child *currently displays,* and circle the 'H' next to any problem the child displayed *in the past.*

Difficulty making friends **C / H** Difficulty maintaining friendships **C/H**

Fights with friends **C/H** Plays mostly with younger children **C/H**

Prefers to play alone **C/H** Gets angry or disappointed by friends easily **C/H**

Uncomfortable with new people **C/H** Over-reacts to problems **C/H**

Bed-wetting or soiling after toilet training? ______ When? ______

If so, were any medical reasons discovered? ______

Walking difficulty after learning to walk ______ Speech difficulties ______

Sleep difficulties ______ Eating difficulties ______ Colic ______ Tantrums ______

Pregnancy

Did the child's mother receive appropriate and adequate medical care? ______

If not, please explain. ______

Please place a mark next to any difficulty that was encountered during pregnancy.

Hospitalization – please describe reason and course of treatment ______

______

Significant illness (describe) ______

Anemia _____ Excessive vomiting _____ Dizziness / fainting _____ Flu or colds _____

High or low blood pressure _____ Unusually high or low weight gain _____

Rh incompatibility _____ Emotional difficulties _____ Toxemia _____ Bleeding _____

House- or bed-ridden? Why? _____________________

Injury to the mother? (describe) _____________________

Smoking during pregnancy? How much? ___________

Please describe alcohol use during pregnancy (how frequently, how much, at which stage of pregnancy). _____________________

Please list any prescription or over-the-counter medications used during pregnancy, including dose and the reason for use _____________________

____

Please list any other drugs used during pregnancy. _____________________

Any other comments about this child's pregnancy. _____________________

____

____

Birth / Labor

Place of birth _____________________ Was this the planned place of birth? _____

Length of pregnancy in weeks _____ Hours of labor _____ Birth weight _____

Apgar score _____ Forceps used? _____ Labor induced? ___ Caesarian delivery? ___

Jaundice? _____ Breech? _____ Was anesthetic used? What type? _____________

Was child placed in the NICU? _____ If so, why? _____________________

Length of hospital stay for mother? _________ Child? _________

Were there any other complications during or immediately after birth (e.g. difficulty breathing, poor eating, failure to thrive)? _____________________

____

____

Developmental Milestones

Please list the ages for the following (leave blank if the child has not yet reached the milestone): first word _____ 2-word sentences _____ crawl _____ walk _____

run _____ toilet trained _____ ride a bike _____ throw a ball _____ dress self _____

bathe self _____ cross the street safely _____ stay home alone _____ tell time _____

Urinary tract infection **C/H** Pain or strong odor while urinating **C/H**
Poor posture **C/H** Frequent or unexplained rashes **C/H** Bruising easily **C/H**
Eczema **C/H** Frequent or unexplained sores **C/H** Seizures **C/H**
Excessive crying **C/H** Frequent or severe low mood **C/H** Severe irritability **C/H**
Biting nails **C/H** Grinding teeth **C/H** Tics / twitches **C/H** Banging head **C/H**
Short attention span **C/H** Easily over-stimulated **C/H** Hyperactive **C/H**
Overly energetic **C/H** Lack of self-control compared to same-aged peers **C/H**
Lengthy illness of any kind (describe) ____________________
Head injury (describe) ____________________
Operations (describe) ____________________
Current medications, dosages, and reasons for use ____________________
____
Does this child wear glasses? ___ Most recent visual examination date ________
Please list all allergies including foods, medications, animals, seasonal, etc. ________
____
Please list all current medications and dosages. ____________________
____
____
Please list name and contact number of any current or previous psychotherapists or counselors. ____________________
____
____

Family History

If any of the child's relatives have a history of any of the following, please place a mark next to it and describe the details.
Learning disability ____________________
Reading difficulty ____________________
Attention Deficit Hyperactivity Disorder (ADHD) ____________________
Alcoholism ____________________
Drug abuse / addiction ____________________
Clinical depression or Anxiety ____________________
Other mental illness ____________________

Psychological or psychiatric treatment ______________________________

Mental retardation ______________________________

Autism or Asperger's Disorder ______________________________

Speech difficulties ______________________________

Heart disease or blood pressure irregularity ______________________________

Migraine headaches ______________________________

Kidney disease, liver disease, or blood disorder ______________________________

Alzheimer's Disease or other dementia ______________________________

History of arrest or criminal prosecution ______________________________

Behavioral disturbance ______________________________

Educational History

Does or did this child attend pre-school? ____ At what ages? ______________

Were there any problems observed or reported in pre-school? Please describe. __________

____

____

Did this child have difficulty transitioning to pre-school or kindergarten? Please describe.

____

____

Has the child been retained a grade? ______ Which grade and why? ______________

____

Has the child skipped a grade? _____ Which grade? __________

Does the child have a history of special education? _____ For what purpose? __________

____

____

Has the child ever had an IEP or 504 plan? ________ Is it current? ____________

Has the child ever been suspended or expelled from school? _____ If so, what were the circumstances and causes of the suspension or expulsion? ______________

____

____

____

What are the child's strongest subjects? ______________________________

What are the child's weakest subjects? ______________________________

Have these changed over time? _____ How so? ______________________________

Does the child have a history of frequent absence from school? _____ Why? __________

____

Please describe any trauma that this child has experienced, including sexual abuse, physical abuse, witness of trauma to others, or any other type. ______________________

____

____

____

Please list all professionals involved in the current or previous care of this child, including doctors, therapists (e.g. psychotherapist, speech therapist), or any other person deemed relevant.

Professional	Contact Number	Treatment Type

Does this child have home responsibilities? How consistently are they done? Please list.

____

____

____

Does the child receive an allowance? How is it spent? ____________________

What does the child like to do with free time? ____________________

____

What hobbies / activities does the child regularly engage in (e.g. sports, art)? __________

____

Does the child have a regular bedtime? What is it? ____________________

What time does the child wake up in the morning? ____________________

Does the child wake up during the night? How many times? Why? __________

____

Please list any other comments on sleeping ____________________

Describe the child's eating habits, including number of meals per day, snacking during the day, and any foods the child has a strong dislike for. ____________________

____

____

How often does the child exercise? Please describe ____________________

____

How many hours per week does the child watch TV? ___ Use the computer? __________

What does the child usually do with the computer? ____________________

Medical History

Please circle the 'C' next to any problem the child *currently demonstrates*. Please circle the 'H' next to any problem a child has demonstrated *in the past.*

Fevers above 104° **C/H** Chicken Pox **C/H** Measles **C/H** Mumps **C/H**

Pneumonia **C/H** Meningitis **C/H** Frequent ear infections **C/H**

Other hearing difficulties (describe) ____________________

Frequent colds **C/H** Chronic cough **C/H** Asthma **C/H** Excessive fears **C/H**

Frequent sinus infections **C/H** Shortness of breath **C/H** Dizziness **C/H**

Heart condition of any kind **C/H** Excessive vomiting **C/H** Constipation **C/H**

Frequent diarrhea **C/H** Frequent or intense stomach pain **C/H** Muscle pain **C/H**

Any other comments you deem relevant to the current evaluation process: ______

Signature of person filling out this form

Date