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Developmental Questionnaire

I. Identifying and Demographic Information

A. *Client Information*

Name:_____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Sex (please circle): F M

Current Address:_____

_____

Home Phone #:_____

School:_____Grade: _____ Handedness:_____

Ethnicity: African-American Asian Hispanic Caucasian Other (Specify): _____

Languages Spoken at Home: English_____ Other_____

Biological or Adopted If Adopted, at what age?_____

Please indicate the names of any childcare providers:

Care Provider _____ Age_____ Length of time_____

Care Provider _____ Age_____ Length of time_____

If you wish us to contact a parent or family member not in the current household, please proved his/her name(s) phone number(s): _____

B. *Family Demographics*

Mother's name:_____ Date of Birth: _____

Home phone: _____ Work Phone: _____

Education: _____ Occupation(s): _____

Father's name:_____ Date of Birth: _____

Home phone: _____ Work Phone: _____

Education: _____ Occupations: _____

Marital Status (Please circle all that apply):

Mother's: Married Divorced Remarried Other (Please specify):_____
Father's: Married Divorced Remarried Other (Please specify):_____

Please list all adults and children living in the household:

Name	Age	Gender	Relationship to child

C. ***Referral Information*** **(**Who referred you to our service?)

Name: _____ Profession: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

II. Presenting Problem(s)

A. ***What concerns do you have and why are you seeking help at this time***?

_____

_____

_____

B. ***What kind of information or assistance are you hoping to obtain***?

_____

_____

_____

C. Are any concerning behaviors or behavior problems? If yes, please describe:

_____

_____

_____

D. ***Are there any specific concerns/problems with studying and/or learning problems? If yes, please describe:***

E. ***Please describe any other problems that may be of relevance to this evaluation:***

F. ***Please describe three or four strengths:***

G. ***Please describe two or three weaknesses:***

H. ***Please list all past neurological, psychiatric, psychological, neuropsychological, educational, speech & language, or other types of evaluations administered.***

Evaluated Where:	**By Whom:**	**Date:**

Please attach copies of these reports; for a comprehensive evaluation, it is essential that all reports be

Please list all past or present interventions, treatment, or remediation the child has received or is receiving, including Physical Therapy, Occupational Therapy, Speech and Language Therapy, etc.:

Received Where: **By Whom:** **Date:**

_____

_____

_____

_____

III. Developmental History

A. *Pregnancy and Birth History*

Number of pregnancies: _____ Number of miscarriages:_____

Describe any difficulties in conception and/or complications that occurred during pregnancy:

_____

_____

Where any medications used during pregnancy? If yes, what kind? _____

_____

Was alcohol or other substances used during pregnancy? Describe frequency and type:

_____

Length of pregnancy was _____ weeks. Length of labor was _____ hours.

Birth weight was ___lbs. ___ oz. Apgar scores: First_____ Second _____

Check any of the following complications that occurred during birth:

Forceps used: ___ Breech birth: ___ Labor induced: ___ Cesarean delivery: _____

Were there any complications or difficulties during labor and delivery?

_____

_____

What was the state of the infant's health at birth? _____

_____

Length of stay in hospital: Mother_____days Child: _____ days

B. ***Developmental History: Infancy*** **(0-12 months)**

As an infant were any of the following traits/descriptions applicable and if so, please explain:
(1) Feeding Problems? _____;
(2) Sleep difficulties? _____;
(3) A response to cuddling? _____;
(4) Fussy, irritable? _____;
(5) Overly active? _____;
(6) Overly passive? _____;
(7) Easy baby? _____; And
(8) Overall temperament? _____.

C. ***Developmental Milestones***

Domain:	Did the following:	Age:	Problems, if any:
Motor	Sat without support		
	Crawled		
	Stood without support		
	Took first steps		
	Walked without assistance		
	Buttoned clothing		
	Tied shoelaces		
	Dressed self		
	Used a crayon		
	Rode tricycle		
	Rode bicycle (without training wheels)		
Toilet Training	Bowl trained		
	Bladder trained, day		
	Bladder trained, night		
Language	Babbled		
	Spoke first words besides “mama” & “dada”		
	Said three-word phrases		
	Spoke in complete sentences		
	Language easy for strangers to understand		
	Could relate happenings well		
Preschool	Named colors		
	Named coins		
Play	Played with dolls/stuffed animals		
	Created and acted out stories		
	Played in cooperation with other children		

D. *Developmental Problems*

	Problem area:	Problem Description:
1.	Unclear Speech	
2.	Understanding Language	
3.	Repeating words or sentences heard	
4.	Eating Problems	
5.	Bed wetting	
6.	Soiling	
7.	Sleeping	
8.	Nail biting	
9.	Thumb sucking	
10.	Grinding teeth	
11.	Tics and/or involuntary movement	
12.	Twitches	
13.	Head banging	
14.	Rocking back and forth	
15.	Impulsivity	
16.	Aggression (biting, scratching, hitting, kicking)	
17.	Separating from parents	
18.	Excessive crying or worrying	
19.	Other problems:	

IV. Educational History

A. *Day Care*

If yes, give name and location of the child caregiver: _____

Between what ages? _____ Full time:_____ Part-time: _____

Any problems in day care? If yes, describe: _____

_____

B. ***Preschool***

If yes, please give name and location of the preschool: _____

Between what ages? _____ Any problems in preschool? Yes No

If yes, describe: _____

_____

C. ***Kindergarten***

If yes, please give name and location of the school: _____

What age? _____

Problems separating? If yes, describe: _____

_____

Any other problems in kindergarten? If yes, please describe: _____

_____

Pre- or post-school program care: _____

_____

D. ***Elementary/High School***

List the names and locations of schools attended:

_____ Grades: _____

_____ Grades: _____

_____ Grades: _____

Name and address of current school: _____

_____

Telephone number: _____

Teacher's name: _____

Please indicate the following problems if these were school experiences:

1. Age child entered 1st grade: _____
2. Has the child been retained a grade in school? If yes, when and why? _____

_____

3. Has the child skipped a grade in school? If yes, when and why? _____

_____

4. Does the child have difficulty with reading? If yes, describe: _____

_____

5. Does the child have difficulty with math? If yes, describe: _____

_____

6. Has the child been placed in a special education/resource room? If yes, hours per day:_____
7. Does the child dislike going to school? If yes, describe: _____

_____

E. ***Current School or Placement (via IDEA, IEP, MDC, or Section 504):***

LD: _____

ED: _____

Speech & Language: _____

OT/PT: _____

Social Work/Counseling: _____

Consultation: _____

F. ***Family Medical History***

Child's Current Medications	
Child's Previous Medications (those taken for longer than 6 months)	
Child's Allergies (food, medicine, other)	
Child's Surgeries/Hospitalizations/Injuries	

(Family Medical History Continued)

MEDICAL HISTORY	CLIENT	MOTHER	FATHER	OTHER
Respiratory: lung disease, asthma, shortness of breath, tuberculosis, pneumonia, bronchitis, emphysema, tumor, other				
Cardiovascular: heart disease, heart murmur, structural defect, arrhythmia, congestive heart failure, high blood pressure, peripheral vascular disorder, chest pain				
Endocrine: thyroid conditions, pituitary disorder, adrenal disease, diabetes, hypoglycemia, tumor				
Ear, Nose, Throat: ear infections, hernia, tinnitus, nose bleeds, tonsillitis, laryngitis, structural defect, difficulty swallowing, deafness, tumor				
Genitourinary: kidney/bladder disease, tumor, structural defect, bed wetting				
Gastrointestinal: ulcers, gastritis, hernia, pancreatitis, colitis, diarrhea, constipation, malabsorption problems, liver/gallbladder disease, tumor, structural defect, cystic fibrosis, stomach aches				
Hematologic: anemia, platelet/coagulations disorders, polycythemia, splenic disease, leukemia, lymphoma				
Immunological: HIV/AIDS, immune system disease				
Integument: discolorations, sores, tumors, pain, itching, rashes, sweating, nail abnormalities				
Musculoskeletal: connective tissue disease, arthritis, fibro myositis, osteoporosis, structural defect, scoliosis, tumor, pain				
Neurological: headaches, seizures, tics, fainting, narcolepsy, tremors, vertigo, meningitis, encephalitis, stroke, brain hemorrhage, head injury, tumor, toxic metal exposure, coma, loss of consciousness, sleep disorder, cerebral palsy, muscular dystrophy, multiple sclerosis, mental retardation, structural defect, Tourette syndrome, learning disability, ADD/ADHD, autism, hyperlexia, processing deficits, obsessive compulsive disorder	See the next page for the client neurological history			
Ocular: blurred vision, double vision, glaucoma, blindness, structural defect, glasses/contact, tumor				
Psychiatric: alcohol/drug abuse, emotional/behavior disorders, manic/depression, bipolar disorder, schizophrenia, physical/sexual abuse, phobias, panic attacks, anxiety, eating disorder	See the next page for the client psychiatric history			
Other Conditions: high fever ≥104, genetic disorders, birth defects, other				

G. ***Client's Neurological and Psychiatric History***

1. Has there been any of the following experienced: meningitis, encephalitis, stroke, brain hemorrhage, narcolepsy, sleep disorders, head injury, coma, loss consciousness, tumor, toxic metal exposure, headaches, seizures, tics, fainting, tremor, vertigo? If so, describe: _____

2. Has your child been diagnosed with: cerebral palsy, muscular dystrophy, multiple sclerosis, mental retardation, central nervous system structural defect? If so, describe: _____

3. Has there been a diagnosed neurobehavioral disorder such as: Tourette syndrome, learning disabilities, dyslexia, ADD/ADHD, autism, Asperger syndrome, hyperlexia, processing deficits, obsessive compulsive disorder, oppositional defiant disorder, nonverbal learning disability, executive function deficits? If so, please describe: _____

4. Has there been a use of cigarettes, drugs, or alcohol? If so, please describe: _____

5. Has there been a diagnosed or symptoms of: emotional/behavior disorders, depression, manic/depression, bipolar disorder, schizophrenia, phobias, panic attacks, anxiety, eating disorder? If so, describe: _____

6. Have you (or your child) been a victim of emotional, physical, or sexual abuse? If so, describe:

H. ***Social-Emotional Development***

1. Are there any problems at home? Yes No If yes, please describe:

_____

_____

_____

2. Are there any social problems with family or peers? Yes No If yes, please describe

_____

_____

_____

3. Is there a preference to be around/play with older, younger, or same age individuals/children?

_____

4. How would describe your or the clients temperament and personality?_____

_____

_____

Additional Comments:_____

_____

_____

_____

Name of person completing this form: _____

If not client then what is your relationship to him/her:

Mother _____ Father _____ Other (Specify):_____