Pediatric Psychological Services

100 HIGH STREET, SUITE 200 WESTWOOD, MA 02090
PHONE/FAX: (781) 898-0127
WWW.PEDIATRICPSYCHOLOGICALSERVICES.COM
AKOVACS@PEDIATRICPSYCHOLOGICALSERVICES.COM

DEVELOPMENTAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Date Completed _____

Client's Name_____
First Middle Last

Age_____ Date of Birth ___/___/_____ Gender_____
(mm/dd/yyyy)

Home Street Address_____

City_____State_____Zip_____

Name of person completing the form _____

Relationship to the Client_____

Home Phone Number_____ Cell Phone Number_____

Email Address: _____

Child's Current School_____

City_____ State_____

Current Grade_____

Who were you referred by? _____

PRESENTING COMPLAINT

What is the reason for your visit?

_____
_____
_____
_____
_____
_____
_____

When did you first become concerned about your child's development? How long have these difficulties been occurring?

_____
_____
_____
_____

In what settings and how frequently do they occur?

_____
_____
_____
_____

Please rate their effect on your child's overall level of functioning:
( ) No effect ( ) Mild ( ) Moderate ( ) Severe

What specific questions would you like to have answered about your child?

_____
_____
_____
_____

FAMILY INFORMATION

Parent's Name _____

Age_____ Date of Birth ____/____/_____ Education_____
(mm/dd/yyyy)

Occupation _____ Living in child's home? (Y) (N)

Parent's Name _____

Age_____ Date of Birth ____/____/_____ Education_____
(mm/dd/yyyy)

Occupation _____ Living in child's home? (Y) (N)

Parents' Current Marital Status _____

Who has custody of the child? _____

Primary language spoken in home _____

Is your child adopted? Yes No
If yes, at what age was he/she adopted and from where?
_____
_____

Other adults frequently involved in parenting the child:

Siblings:

Name	Age	Grade	Lives in child's home (Y/N)

Please describe the home environment (circle): Outstanding Normal Chaotic

MEDICAL AND HEALTH INFORMATION

Has your child had any surgery, serious illnesses or accidents? Yes No

Does your child have allergies? (Environmental or food allergies) Yes No

Does your child have asthma or any other respiratory problems? Yes No

Does your child have any medical conditions? Yes No

If you answered yes to any of the above questions, please explain: _____
_____
_____
_____

Does your child take any medications regularly? Yes No
If yes, please list:
_____
_____

Has your child ever been treated or evaluated by a:

Neurologist?	Yes	No
Psychologist?	Yes	No
Other Medical or Developmental Specialist	Yes	No

If yes, please list the date of visit, name of the doctor, and explain reason for visit and outcome:

_____
_____
_____

Is your child currently in any type of therapy (e.g., OT, PT, SLP, ABA, etc.):

If yes, please list the type of therapy, dates of treatment, name of the provider, and explain reason for visit:

_____
_____
_____

Does your child have a history of ear infections? Yes No

Does your child have tubes placed in his/her ears? Yes No

If yes, when were they placed? _____

Does your child have any vision problems? Yes No

If yes, please explain_____

When was your child's last hearing exam? Were results normal? Yes No

When was your child's last vision exam? Were results normal? Yes No

How would you describe your child's overall health? Good Poor

Pediatrician's Name _____

Pediatrician's
Address_____Phone_____

PRENATAL HISTORY

While pregnant, did mother have:

a. High blood pressure	Yes	No
b. Excessive Vomiting	Yes	No
c. Bleeding or spotting	Yes	No
d. Kidney Disease	Yes	No
e.Toxemia/Pre-eclampsia	Yes	No
f. Gestational diabetes	Yes	No
g. Threatened Miscarriage	Yes	No
h. German Measles (Rubella)	Yes	No
i. Illness other than cold or flu	Yes	No
j. Hospitalization Required	Yes	No
k. Premature labor	Yes	No
Was there any substance/alcohol abuse?	Yes	No

If yes, please explain _____
_____
_____

Did mother take any medications during pregnancy Yes No
If yes, please explain _____
_____
_____

BIRTH HISTORY

Place of Birth: _____
When was baby born (weeks): _____
Birth weight of baby:_____
Was labor induced: Yes No
Was labor helped by medication: Yes No
Was the pregnancy difficult: Yes No
If Yes, please explain: _____
_____
Duration of labor: _____
What was the method of delivery? _____
If Caesarean, why?_____
How long was the hospital stay for mother_____and baby?_____
During hospital stay, did baby have any of the following:

a. Jaundice	Yes No	
b. Antibiotic treatment	Yes No	
c.Fever	Yes No	
d.Blue spells	Yes No	
e. Convulsions	Yes No	
f. Stay in the NICU	Yes No	If Yes, how long: _____
g. Incubator Care	Yes No	
h.Infection	Yes No	

If yes, please explain _____

_____
_____

DEVELOPMENTAL HISTORY

Approximate age at which your child reached these developmental milestones:
Hold up head _____ Roll over_____ Sit unsupported_____
Crawled_____ Stand alone_____ Walk_____ Run_____
Jump_____ Ride a bike_____
Respond to Own Name_____ Point to show interest in something_____
First word_____ Two-word phrases_____ Sentences_____
Toilet trained for urine_____ bowels_____ Current Accidents? Yes No
Feed her/himself_____ Dress her/himself_____
Read sight words_____ Name Colors_____

Has there been any regression or loss of previously learned skills? Yes No
If yes, please explain _____
_____

SCHOOL AND EDUCATIONAL INFORMATION

Age began daycare/nursery or preschool _____
Age started Kindergarten _____
Does your child refuse to go to school Yes No
Does your child enjoy school Yes No
Is your child in special classes? Yes No
Is your child on a 504 Plan? Yes No
Does your child have an IEP? Yes No
If yes, please explain_____
Has your child ever repeated a grade? Yes No
If yes, which grade_____
Has your child ever skipped a grade? Yes No
If yes, which grade_____
Do you feel that your child is making progress at school? Yes No
Are you satisfied with the school program for your child? Yes No
Briefly describe any academic problems that your child is facing at school_____
_____
_____
_____
_____

Does your child face trouble in these specific learning areas:
a.Math Yes No
b.Reading Yes No
c.Writing Yes No
d. Verbal/Oral Expression Yes No
e. Understanding instructions Yes No

SOCIAL AND EMOTIONAL INFORMATION

List your child's major interest and hobbies_____

_____
_____

Is your child involved in extracurricular activities? Yes No
If yes, what kind_____

Does your child have difficulty making friends? Yes No
If yes, please explain _____
_____
_____

Briefly describe any behavioral problems that your child is facing at home/school:
_____
_____
_____

Are there any past or present circumstances which you think could be related to your child's present difficulties?_____
_____
_____

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, abuse, accident, etc.)? Yes No
If yes, please describe _____
_____

Do any family members have (or have had) a psychological or developmental disorder? Yes No
If yes, who and what kind? _____
_____
_____
_____
_____

Please add any other comments that will help us understand your child better
_____
_____
_____
_____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Pediatric Psychological Services for myself and/or my child.

_____ _____ _____
Parent or Guardian Signature Print Date