# Pediatric Psychological Services

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# 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_____

School Street Address_____

City_____State_____Zip_____

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

Mother's Name _____

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

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

Father'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 received all of his/her vaccinations? Yes No

If you answered no, which ones were not given and why?

_____

_____

Has your child ever been examined 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

Where was baby born: _____
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_____

Please mark any areas which constitute a problem for your child:

( C = Current difficulties; H = History of previous difficulties)

| C | H | | C | H | |
|---|---|---|---|---|---|
| [ ] | [ ] | Difficulty making friends | [ ] | [ ] | Frequent/excessive crying |
| [ ] | [ ] | Difficulty maintaining friendships | [ ] | [ ] | Short attention span |
| [ ] | [ ] | Fights with friends | [ ] | [ ] | Easily over-stimulated |
| [ ] | [ ] | Prefers to play alone | [ ] | [ ] | Overly energetic |
| [ ] | [ ] | Uncomfortable with new people | [ ] | [ ] | Easily distracted |
| [ ] | [ ] | Plays mostly with younger children | [ ] | [ ] | Poor concentration |
| [ ] | [ ] | Aggressive/assaults others | [ ] | [ ] | Lack of self-control |
| [ ] | [ ] | Gets angry/disappointed by friends easily | [ ] | [ ] | Hyperactive |
| [ ] | [ ] | Cruel to other children | [ ] | [ ] | Impulsive |
| [ ] | [ ] | Distrustful of others | [ ] | [ ] | Frequently disobedient |
| [ ] | [ ] | Poor empathy | [ ] | [ ] | Breaks things |
| [ ] | [ ] | Speech and language difficulties | [ ] | [ ] | Chronic lying |
| [ ] | [ ] | Repeats words of others | [ ] | [ ] | Stealing |
| [ ] | [ ] | Unusual vocal intonation | [ ] | [ ] | Not trustworthy |
| [ ] | [ ] | Lack of attachment | [ ] | [ ] | Self-injurious behaviors or threats |
| [ ] | [ ] | Poor eye contact | [ ] | [ ] | Violent temper |
| [ ] | [ ] | Immature | [ ] | [ ] | Cruel to animals |
| [ ] | [ ] | Excessive fears/worries | [ ] | [ ] | Fire setting |
| [ ] | [ ] | Biting nails | [ ] | [ ] | Bizarre behavior |
| [ ] | [ ] | Grinding teeth | [ ] | [ ] | Alcohol use |
| [ ] | [ ] | Indecisive | [ ] | [ ] | Drug use |
| [ ] | [ ] | Banging head | [ ] | [ ] | Tics/twitches |
| [ ] | [ ] | Tantrums: Frequency _____ Duration _____ | [ ] | [ ] | Eating difficulties |
| [ ] | [ ] | Overreacts to problems | [ ] | [ ] | Sleep difficulties |
| [ ] | [ ] | Severe irritability | [ ] | [ ] | Colic as an infant |
| [ ] | [ ] | Hostile/angry mood | [ ] | [ ] | Sensory sensitivity (e.g., sound, clothing) |
| [ ] | [ ] | Often sad | [ ] | [ ] | Other: |

If marked 'C' or 'H', please explain:
_____
_____
_____
_____

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 _____

_____

Has your child ever had counseling, psychotherapy, or a psychological or psychiatric evaluation? Yes No

If yes, date(s) _____

Agency or name of therapist _____

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