DEVELOPMENTAL HISTORY QUESTIONNAIRE
(For Ages 2-19)

Directions: Please ***print*** your answers neatly so we can read your responses. Although this questionnaire is lengthy, the information you provide will help us better understand your child's developmental, medical, educational, and behavioral history and contribute to a more thorough evaluation.

IDENTIFYING INFORMATION

Person Completing this Form:_____ **Today's Date:** ____-____-_____
First Middle Last

What Is Your Relationship to the Child/Adolescent?_____

Child/Adolescent's Name:_____ **Sex:** ☐ **M** ☐ **F** **DOB:**_____-_____-_____
First Middle Last

Your Address:_____

Your Cell Phone Number:_____ **Your Email Address:**_____

REASONS FOR EVALUATION:

Please list the reason(s) your child or adolescent is being referred to us:

1. _____

2. _____

3. _____

When did these problems begin?

_____

What are your goals for seeing us?

_____

_____

Is this evaluation related to any legal issues, such as child custody, Medicaid waiver, or Social Security Disability?

☐Yes ☐ No If yes, please describe:_____

What type of services are you seeking? (Check all that apply.)

☐ Psychological Testing	☐ Diagnostic Clarification	☐ Assess for School/Learning Problems
☐ Individual Counseling/Therapy	☐ Family Counseling/Therapy	☐ Assess for Legal Charges
☐ Assess for Disability or Waiver Services	☐ FINS Adjudication	☐ Doctor/Primary Care Provider Referral

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FAMILY INFORMATION:

Mother/Guardian Name: _____ Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Father/Guardian Name: _____ Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Parents are:
- ☐ Married
- ☐ Unmarried, Living Together
- ☐ Never Married, Living Together
- ☐ Separated
- ☐ Divorced
- ☐ Mother Deceased
- ☐ Father Deceased

Child lives with: (Check all that Apply)
- ☐ Biological Mother
- ☐ Biological Father
- ☐ Step-parent
- ☐ Adoptive Parent (specify) _____
- ☐ Grandparent
- ☐ Legal Guardian (specify) _____
- ☐ Other (specify) _____
- ☐ Split custody (Lives in homes of both divorced parents)

SIBLING INFORMATION:

Name of sibling	Sex	Age	Same Father?	Same Mother?	List any health/behavior/ learning problems	Lives with child?
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N

How well does your child get along with his/her siblings?

☐ Very Well ☐ Good ☐ Average ☐ Fair ☐ Poor

Is English the child's primary speaking language? ☐Yes ☐ No

If no, what is the child's primary language? _____ What is the child's secondary language? _____

CHILD CARE AND DISCIPLINE:

Who is primarily responsible for the child's care? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Who is mainly in charge of discipline in the home? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Please describe any misbehavior patterns in the home and classroom._____

Please describe discipline techniques used with the child/adolescent and effectiveness._____

_____

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FAMILY PSYCHIATRIC HISTORY: (Check all that apply.)

Condition/Disorder	Father	Mother	Brother	Sister	Grandparent	Aunt/Uncle
Alcohol/Drug Addiction						
Anxiety						
ADHD						
Autism Spectrum Disorder						
Bipolar Disorder						
Depression						
Epilepsy/Seizure Disorder						
Genetic Disorder/Condition						
Intellectual Disability						
Jail Time/Incarceration						
Language Disorder						
Learning Disability						
Mental Health Hospitalization						
Motor or Vocal Tics/Tourette's						
Psychosis or Schizophrenia						
Special Education Services						
Speech Difficulties/Therapy						
Substance Abuse Arrests/DWI						
Suicidal Thoughts/Attempts						
Other:_____						
Other:_____						

PREGNANCY AND BIRTH HISTORY:

Parents' ages when child/adolescent was born: Mom was _____years old Dad was _____ years old

Was this pregnancy full term? ☐Yes ☐ No If not, how many weeks before or after the expected due date was the baby born? _____ weeks ☐ Before ☐ After due date

Pregnancy number: 1st, 2nd, 3rd, 4th, other ____ Totals: # of pregnancies _____ # of miscarriages _____

Was this a multiple birth? ☐Yes ☐ No ☐ Don't Know; if yes: ☐Twins ☐ Triplets ☐Quadruplets

Were the babies identical? ☐Yes ☐ No ☐ Don't Know

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.):

_____

Mother's health during pregnancy:

☐ No health problems during pregnancy
☐ Poor weight gain
☐ Severe nausea (☐ with dehydration)
☐ Seizures
☐ High blood pressure
☐ Other (specify)_____
☐ Health during pregnancy not known
☐ Excessive weight gain (>30 pounds)
☐ Preeclampsia/Toxemia
☐ Infections (Flu, measles, CMV)
☐ Rh (blood group) factor incompatibility

List medications taken during this pregnancy: _____

_____

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Did the mother consume alcohol during this pregnancy? ☐Yes ☐ No If yes, how many drinks per week? _____

Did the mother smoke during pregnancy? ☐Yes ☐ No If yes, how many cigarettes per day (average)? _____

Did the mother consume illicit drugs during the pregnancy? ☐Yes ☐ No If yes, which drugs and how much?

_____

LABOR AND DELIVERY:

☐ No problems during labor and delivery ☐ Not known Was prenatal care provided during pregnancy? ☐Yes ☐ No

Was medication given to prolong pregnancy? ☐Yes ☐ No If yes, at what week of pregnancy? _____

Was medication given to induce delivery? ☐Yes ☐ No

Please note whether any problems occurred during labor or delivery (check all that apply):

☐ **EXCESSIVE BLEEDING**	☐ **FORCEPS USED**
☐ Meconium staining	☐ Umbilical cord around baby's neck
☐ Fever or infection of mother	☐ Breathing difficulties of child
☐ Placenta previa or abruption	☐ Placenta (water) broke more than 1 day before delivery

☐ Other (specify): _____

Child was born: ☐head first ☐breech (feet first) ☐vaginal ☐Cesarean (Why? _____)

Birth weight _____ lbs _____ oz **Length** _____ in. (if known) **Head circumference** _____ in. (if known)

Apgar Scores (if known): _____ at 1 min _____ at 5 min

NEWBORN PERIOD:

Was the child healthy as a newborn? ☐Yes ☐ No If not, please describe the problems and treatment: _____

_____

Was the child born with any birth defects? ☐ Yes ☐ No If yes, explain:_____

_____

Did the child require treatment in a newborn intensive care unit? ☐ Yes (for _____ days) ☐ No If yes, please describe. _____

_____

Did the baby require any special care immediately after birth? ☐ No ☐ Yes If yes, please describe. _____

_____

Check all that apply below.

☐ Breathing problems (requiring ☐ oxygen ☐ ventilator (with a tube in windpipe)
☐ Was cyanotic/turned blue
☐ Placement in an incubator
☐ Blood transfusions
☐ Significant muscle weakness or paralysis
☐ Poor muscle tone
☐ Seizures
☐ Feeding difficulties
☐ Excessive sensitivity to noise/stimulation
☐ Jaundice treated with lights
☐ Infection
☐ Surgery (describe): _____

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DEVELOPMENTAL HISTORY:

Have you noticed any past or current delays in your child/adolescent's development? ☐ Yes ☐ No

If so, how old was your child when you first became concerned?_____

What areas of development were/are you concerned about?_____

Social Development

As an infant, did/was the child: *(Describe to right of check mark.)*

Difficult to feed?	☐ Yes ☐ No	_____
Difficult to get to sleep?	☐ Yes ☐ No	_____
Enjoying cuddling?	☐ Yes ☐ No	_____
Easy to comfort?	☐ Yes ☐ No	_____
Cheerful?	☐ Yes ☐ No	_____
Sociable?	☐ Yes ☐ No	_____
Tend to be fussy/irritable?	☐ Yes ☐ No	_____
Make appropriate eye contact?	☐ Yes ☐ No	_____
Respond to his/her name?	☐ Yes ☐ No	_____

During the first four years of life, were any special problems noted in the following areas? (*If yes, please describe below.)*

Anger outbursts	☐ Yes ☐ No	_____
Separating from parents	☐ Yes ☐ No	_____
Excessive crying	☐ Yes ☐ No	_____
Playing with other children	☐ Yes ☐ No	_____
Overactivity, in constant motion	☐ Yes ☐ No	_____
Very stubborn, challenging	☐ Yes ☐ No	_____

Speech and Language Development

Did you notice any delays in the child's language development? ☐ Yes ☐ No

If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

Show interest in sound *(by 3 months)*	☐ Yes ☐ No	_____
Babbling *(by 4 to 6 months)*	☐ Yes ☐ No	_____
Understanding words *(by 6-11 months)*	☐ Yes ☐ No	_____
Speaking first words *(by 12 months)*	☐ Yes ☐ No	_____
Speaking in short phrases *(by 24 months)*	☐ Yes ☐ No	_____

Motor Development

Did you notice any delays in the child's motor development? ☐ Yes ☐ No

If yes, please specify: _____

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Did the following milestones develop on time? *Please specify age (year/month).*

Turn over (by 6 months)	☐ Yes ☐ No	_____
Sit alone (by 9-12 months)	☐ Yes ☐ No	_____
Crawl (by 9-12 months)	☐ Yes ☐ No	_____
Stand without support (by 9-12 months)	☐ Yes ☐ No	_____
Walk without support (by 12-18 months)	☐ Yes ☐ No	_____
Running	☐ Yes ☐ No	_____

Which hand does your child use for writing or drawing? ☐ Right ☐ Left ☐ Both

Does your child grip writing instruments correctly when writing and drawing? ☐ Yes ☐ No _____

Daily Living

Has your child completed toilet training? ☐ Yes ☐ No

If not toilet trained, does he/she <u>still have</u> ☐ daytime bowel accidents? ☐ nighttime bowel accidents?

If not toilet trained, does he/she still have ☐ daytime bladder accidents? ☐ nighttime bladder accidents?

If toilet trained, how old was your child when he/she stopped having toileting accidents?

During the Day: _____ During the Night: _____

Did bedwetting resume after toilet training was completed? ☐ Yes ☐ No If yes, until what age? _____

Did bed-soiling resume after toilet training was completed? ☐ Yes ☐ No If yes, until what age? _____

Does your child have difficulty with overreacting or underreacting to sensory information? ☐ Yes ☐ No
If yes, please describe below:

Tolerating Food Textures	☐ Yes ☐ No	_____
Gagging or Vomiting	☐ Yes ☐ No	_____
Tolerating Clothing	☐ Yes ☐ No	_____
Tolerating Touch from Others	☐ Yes ☐ No	_____
Does Not Notice Pain	☐ Yes ☐ No	_____
Other		_____

Significant <u>LOSS</u> of an acquired skill or skills (not just a delay)? For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning ☐ Age of loss: _____ months; Explain: _____

_____

Speech/language ☐ Age of loss: _____ months; Explain: _____

_____

Problem solving ☐ Age of loss: _____ months; Explain: _____

_____

Motor coordination ☐ Age of loss: _____ months; Explain: _____

_____

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Bladder/bowel control ☐ Age of loss: _____ months; Explain: _____

_____

MEDICAL HISTORY:

Who is your child's primary care doctor? _____ Phone Number:_____

Is your child followed by other healthcare professionals or specialists? ☐Yes ☐No If yes, name(s) and specialty(ies):

_____

☐ No serious illnesses or injuries in the **past** ☐ No serious illnesses or injuries **now**

Date	Age	Diagnosis/Illness	Past	Now
		SERIOUS INJURIES	☐	☐
		Serious head injury	☐	☐
		Other serious injury	☐	☐
		Loss of consciousness	☐	☐
		SLEEP PROBLEMS	☐	☐
		NEUROLOGICAL PROBLEMS	☐	☐
		Birth abnormality	☐	☐
		Seizures (type:_____)	☐	☐
		Other:	☐	☐
		VISION PROBLEMS	☐	☐
		Vision problems at birth	☐	☐
		Requires glasses/contacts	☐	☐
		Other: _____	☐	☐
		HEARING PROBLEMS	☐	☐
		Hearing problems at birth	☐	☐
		Deafness	☐	☐
		Chronic/repeated ear infections	☐	☐
		Ear tubes	☐	☐
		Other: _____	☐	☐
		DENTAL PROBLEMS	☐	☐
		Abnormal/missing teeth	☐	☐
		Extractions/cavities	☐	☐
		Dental braces	☐	☐
		Other: _____	☐	☐

Date	Age	Diagnosis/Illness	Past	Now
		LUNG/BREATHING PROBLEMS	☐	☐
		Asthma	☐	☐
		Pneumonia	☐	☐
		Apnea or irregular breathing	☐	☐
		Other:	☐	☐
		STOMACH/BOWEL PROBLEMS	☐	☐
		Swallowing problems	☐	☐
		Gastroesophageal reflux	☐	☐
		Chronic abdominal pain	☐	☐
		Chronic diarrhea	☐	☐
		Chronic constipation	☐	☐
		Other:	☐	☐
		KIDNEY/BLADDER PROBLEMS	☐	☐
		Abnormalities at birth	☐	☐
		Kidney/bladder infections	☐	☐
		Other:	☐	☐
		MUSCLE/BONE/JOINT PROBLEMS	☐	☐
		Abnormalities at birth	☐	☐
		Scoliosis or spinal curvature	☐	☐
		CIRCULATORY PROBLEMS	☐	☐
		Anemia	☐	☐
		Sickle cell disease	☐	☐
		Chronic low platelet count	☐	☐
		Bleeding/bruising problem	☐	☐

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		SKIN PROBLEMS	☐	☐
		Eczema	☐	☐
		Ash leaf patches	☐	☐
		Other: _____	☐	☐
		GROWTH PROBLEMS	☐	☐
		Failure to gain weight	☐	☐
		Obesity	☐	☐
		Short stature	☐	☐
		Tall stature	☐	☐
		Other:_____	☐	☐
		HEART PROBLEMS	☐	☐
		Heart abnormalities at birth	☐	☐
		Heart surgery	☐	☐
		Heart rhythm abnormalities	☐	☐
		High blood pressure	☐	☐
		Other:_____	☐	☐

		Other: _____	☐	☐
		HORMONE PROBLEMS	☐	☐
		Diabetes Mellitus	☐	☐
		Early puberty	☐	☐
		Other: _____	☐	☐
		MENTAL HEALTH PROBLEMS	☐	☐
		ADHD	☐	☐
		Oppositional defiant disorder	☐	☐
		Anxiety disorder	☐	☐
		Obsessive-compulsive disorder	☐	☐
		Depression	☐	☐
		Bipolar disorder	☐	☐
		Schizophrenia	☐	☐
		Tic disorder (e.g., Tourette's)	☐	☐
		Intellectual disability	☐	☐
		Eating disorder	☐	☐

I have confirmed with my child's primary care doctor that his/her immunizations are up to date. ☐ Yes ☐ No
If no, explain:_____

Specialized neurological or genetic tests:

Has genetic or neurological testing been performed? ☐ Yes ☐ No

Check If performed	Date (MM/YY)	Test/Procedure	Normal Result	Abnormal Result (Describe)	Unknown Result
☐		EEG (Brain wave testing)	☐	☐	☐
☐		CT Scan	☐	☐	☐
☐		MRI Scan	☐	☐	☐
☐		PET/SPECT scan	☐	☐	☐
☐		Other Scan (specify:_____)	☐	☐	☐
☐		Chromosomal	☐	☐	☐
☐		DNA Testing for Fragile X Syndrome	☐	☐	☐
☐		Other genetic test:_____	☐	☐	☐

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List all hospitalizations and surgeries for the child, include overnight stays (medical or behavioral).

☐ No past hospitalizations or surgery

Reason for hospitalization OR type of surgery	Age	Length of stay

Allergies (to medications, foods, environmental antigens, etc.)

☐ No past or current allergies

Source (medication, food, pollen, etc.)	Describe reaction (breathing issues, rash, etc.)

Current Medications

☐ No medications taken now.

Medication Name	Dosage	How Long on Medication?	Condition Treated	Improvement?	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No

Name of healthcare professional who prescribes above medications: _____

RESOURCES: Please indicate resources/services received, both currently and in past.

☐ No resources/services are being received now

Type of Services	History of Service			Name of Agency/Provider	Dates Treated	Improvement?	
Early Childhood Developmental Services	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Speech/Language Therapy	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Occupational Therapy	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Physical Therapy	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Mental Health Counseling	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Case Management	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Other?_____	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No

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EDUCATIONAL HISTORY:

Current School: _____ Grade in School:_____

Name of Current Teacher(s):_____

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, which grade(s)?_____ Why held back?_____

What is(are) your child's most difficult subject(s)? _____

What is(are) your child's best school subject(s)? _____

Please describe your child's attitude about school. _____

Has your child ever been suspended? ☐ Yes ☐ No If yes, how many times, which grades, and why?

_____

Has your child ever been expelled? ☐ Yes ☐ No If yes, how many times, which grades, and why?

_____

Is your child currently on a formal education plan in school? ☐ Yes ☐ No

If yes, please check: □ IEP □ Section 504 Plan

What best describes the child's current educational program?

Full time in a regular class	☐
Time split between regular and special education classes	☐
Special education class	☐
Aide/Paraprofessional or extra help	☐
Specialized school	☐
Homeschooled	☐

Please indicate the school, specialized services, and performance for each year of school.

Grade in School	Name of School	Any Specialized Services? (SPED, SLT, OT, PT, etc.)	Average Academic Grades (As, Cs, etc.)	Behavioral Performance
Age 3-5 (PreK)				
Kindergarten				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

LEGAL HISTORY:

Has child protective services (DHS, DCFS) ever investigated allegations of abuse or neglect of your child? ☐ Yes ☐ No

If yes, when were allegations investigated? _____ In what state(s)?_____

Who was the alleged offender(s)?_____

What was the outcome of the investigation?_____

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Has your child ever been adjudicated in a FINS (Family In Need of Services) case? ☐ Yes ☐ No If yes, please describe below:

_____

_____

Has your child/adolescent ever been arrested or convicted for committing crimes? ☐ Yes ☐ No If yes, please describe below.

_____

_____

SOCIAL AND BEHAVIORAL FUNCTIONING:

Peer Relationships (Please indicate how the child relates to peers:)

☐ Has problems relating to other children
☐ Has difficulty making friends
☐ Fights frequently with peers
☐ Prefers playing with younger children
☐ Prefers playing with older children
☐ Prefers to play alone
☐ Has a best friend
☐ Seems uninterested in friendships/peers
☐ Friends tend to be negative influences
☐ Positive relationships with peers

What role does your child or adolescent tend to take in peer groups? ☐ Leader ☐ Follower ☐ Some of Each

How many friends does the child have? _____ Does he/she have problems keeping friends? ☐ Yes ☐ No

RECREATIONAL INTERESTS:

What does your child enjoy?

☐ Sports _____

☐ Hobbies_____

☐ Other _____

What are your child's personal strengths?

_____

_____

What do you enjoy most about your child?

_____

_____

What are your hopes for your child?

_____

RECENT FAMILY STRESSORS:

Please describe any recent family, school, or social stressors that have occurred in your child's life.

_____

_____

_____

_____

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OTHER COMMENTS:

Please let us know anything else about your child/adolescent that would help us understand him/her better.

_____

_____

REMINDERS

1. **Please double check to ensure all questions are answered on this *Developmental History Questionnaire*.**

2. **Return this questionnaire as well as the *Intake Form* to our office.**

3. **Please take all active insurance cards to our office with these forms.**

4. **After we receive all this important information and a referral from your child or adolescent's health care provider (if required), we will schedule an initial intake appointment as soon as an opening is available.**

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