# DEVELOPMENTAL QUESTIONNAIRE

**Please answer all questions as best you can. If you are unsure about some information, please give a "best guess" estimate. All information provided will remain confidential.**

Today's Date_____ / _____ / _________

Child's Name ___________________________________________ Date of Birth: _____ / _____ / _________

Name of person completing questionnaire______________________________________________

Relationship to child______________________________________________________________

Address:

____________________________________________________________________________________

Phone number _______________________________ Email _________________________________________

Chief problem:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Does child have any school behavior problems?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Does child have any problems with schoolwork (besides chief problem)?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please describe this child's strengths:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please describe this child's weaknesses:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

**FAMILY HISTORY**

Please list siblings as appropriate:

| Sibling Name | Sibling Age | Full/Half Sibling |
|---|---|---|
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| | | |
| | | |

**<u>CIRCLE ONE</u>: Is this child:** biologic? adopted? foster child? grandchild?

Whom does this child live with at the present time? (include parents, brothers, sisters, grandparents, friends, etc.)

________________________________________________________________________________

What language(s) is used at home? ____________________________________________________________

Parent 1 Name:______________________________ Parent 1's education? ________________________________

Parent 1's occupation? ____________________________________________________________________

Parent 2 Name:______________________________ Parent 2's education? ________________________________

Parent 2's occupation? ____________________________________________________________________

Are parents: married? separated? divorced? not married-together? ____________________________

**Please list anybody in the <u>child</u>'s family with problems in school:**

| <u>Person</u> (e.g., parents, grandparents, brothers, sisters, uncles, aunts, etc.) | <u>Problem</u> (e.g., language, reading, writing, spelling, mathematics, foreign languages, etc.) |
|---|---|
| | |
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**Please list anybody in the <u>child</u>'s family with behavior problems:**

| <u>Person</u> | <u>Problem</u> (overactive, restless, withdrawn, trouble with the law, etc.) |
|---|---|
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**Has anybody in the <u>child</u>'s family had (please check any that apply):**

- ☐ SEIZURES/EPILEPSY
- ☐ HYDROCEPHALUS
- ☐ PSYCHOTIC DISORDER (Schizophrenia)
- ☐ AUTISM SPECTRUM DISORDER
- ☐ ADHD/ADD
- ☐ TICS/TOURETTE'S
- ☐ THYROID CONDITION
- ☐ OTHER NEUROLOGICAL DX
- ☐ MOOD DISORDER (Depression, Bipolar)
- ☐ ANXIETY DISORDER (Panic, OCD)
- ☐ INTELLECTUAL DISABILITY
- ☐ LEARNING DISABILITY
- ☐ GENETIC SYNDROME
- ☐ OTHER:__________________________

**PREGNANCY AND BIRTH HISTORY**

Did doctor note any problems? **Yes** **No** Describe: ____________________________________________

Was mother on any medication? **Yes** **No** If yes, what medication & why? ______________________________

Did mother smoke? **Yes** **No** If yes, amount, frequency, & when? ______________________________

Did mother drink alcoholic beverages? **Yes** **No** If yes, amount, frequency, & when?______________________

Did mother use drugs? **Yes** **No** If yes, what kind, amount, frequency, & when? ______________________

Were there any problems with labor? **Yes** **No** If yes, describe (why):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Were there any problems with delivery? **Yes** **No** If yes, describe:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Child's **Birth Weight**? ____________________

Was a Caesarean section performed? **Yes** **No** If yes, **Emergent** or **scheduled**? For what reason? Describe:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Were there any birth defects or complications? **Yes** **No** If yes, describe:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Which pregnancy was this (first, second, third, etc.)? ______________

Was this child full-term? (i.e., was he/she born at the expected time?) **Yes** **No** If No, how many weeks gestation?________

**DEVELOPMENTAL HISTORY**

Please indicate the age at which your child first demonstrated each behavior (If you are uncertain of the exact age, please indicate whether the skill was achieved within normal expectations *or* delayed in development):

Sat alone ______________________ Spoke first word____________________

Walked alone ____________________ Put several words together______________

Has this child ever lost developmental skills? **Yes** **No** If yes, describe: ________________________________________

________________________________________________________________________________________________

Has this child had difficulty separating from you or other caregivers? **Yes** **No** at what age? ______________

When was this child toilet trained - for day time? _________ for night time? ___________________

Which hand does this child prefer? **Right** **Left** **Mixed** **No Preference**

Does this child play with **older,** **younger,** ***OR*** **same-age** **children**? (Please Circle ONE)

Does child have opportunity to play with children the same age? **Yes** **No**

Has this child ever had psychotherapy or counseling? **Yes** **No** if yes, when? ______________________________________

with whom? ________________________________________________________________________

for what? __________________________________________________________________________

**MEDICAL HISTORY (Child)**
**Has the child experienced any of the following (please check any that apply):**

- ☐ SERIOUS ILLNESS
- ☐ HOSPITALIZATION
- ☐ SURGERY
- ☐ ASTHMA/ALLERGIES
- ☐ VISION PROBLEMS
- ☐ HEARING PROBLEMS
- ☐ SEIZURES
- ☐ FREQUENT EAR INFECTIONS
- ☐ HEAD INJURIES
- ☐ PE TUBES
- ☐ HEADACHES
- ☐ STOMACHACHES
- ☐ SLEEP PROBLEMS
- ☐ EATING PROBLEMS

List **medications & dosages** child currently takes:____________________________________________________________

Has your child ever been evaluated by Neurology? **Yes** **No** If Yes, describe tests (e.g., MRI, EEG) & findings: ________________

________________________________________________________________________________________________

Has your child ever been evaluated by Genetics? **Yes** **No** If Yes, describe tests (e.g., Fragile X, FISH) & findings:______________

________________________________________________________________________________________________

**SCHOOL HISTORY**

Present grade (if not in school, please indicate) _____________ Ever repeated a grade? **Yes** **No** If yes, which grade? ___________

In what grade did school problems become noticeable? __________________

Has child been evaluated before? **Yes** **No** If Yes, how many times? _________ when was last evaluation?___________________

What specific educational interventions have been made? (e.g., speech therapy, occupational therapy, physical therapy, etc.)

______________________________________________________________________________

______________________________________________________________________________

Does child receive special education services now? **Yes** **No** If Yes, what & how often____________________

______________________________________________________________________________

Has child changed schools frequently? **Yes** **No** How many schools has he/she attended? ________

What school does this child go to now? (please give full address):

____________________________________________________________

Name of School

____________________________________________________________

Street City State Zip Code

Who is the best person to contact for details about the child's schoolwork?________________________

this person's relationship to child? ______________________________________________

Who suggested that you get this evaluation at this time? ________________________________

List any diagnoses (medical, psychiatric, behavioral, school, etc.) your child has been previously given:

______________________________________________________________________________

______________________________________________________________________________

**Additional Comments:** ______________________________________________________________

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