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CHILD DEVELOPMENTAL QUESTIONNAIRE

Child's Name/DOB _____ Date _____

Parent/Guardian Name _____

Reason for Referral

Who referred you to my practice?

_____

What prompted you to seek help at this time?

_____
_____
_____
_____

How do you feel I can best help you?

_____
_____
_____

In order to best help you your child, I would like to understand a bit more about your family history and, in particular, your child's history. I will start by asking about the pregnancy.

Pregnancy/Birth History

Birth Child _____

Adopted Child _____ If yes, adopted at what age and what ethnicity _____

Mother's age at pregnancy _____ Length of Pregnancy _____ Was pregnancy planned? _____

Were mother and father together during the pregnancy? _____

Was mother working during the pregnancy? ____ At home or outside the house _____

Were there any unusual factors relating to the pregnancy or birth:

Medical complications: _____

Psychological distress: _____

Other (specify): _____

Did mother use any of the following during pregnancy (please circle all that apply and then list kinds of substance and regularity of use:

Alcohol _____

Drugs _____

Prescription medication _____

Smoking _____

Was the delivery: (please circle all that apply)

Normal Breech Cesarean Forceps Induced

What was the child's birth weight? _____

How long was the child in the hospital? _____How long was the mother in the hospital? _____

Did mother breastfeed? _____ When was the baby weaned (age) _____

How did parents feel with baby during first several months (circle all that apply)

Mother	**Father**
Loving	Loving
Mixed Feelings	Mixed Feelings
Frustrated	Frustrated
Worried	Worried
Happy	Happy
Fearful	Fearful

Were there any other primary caretakers of the child in infancy? _____

If so, please state who and give the nature of the person's relationship with the child:

Childhood History

Describe your child as an infant – birth to one year (i.e. irritable, fussy, happy, etc.)

How did the baby behave with other people? _____

When the baby wanted something, how insistent was she/he _____

How would you rate the activity level of the child as an infant/toddler (very high, moderate, not active at all) _____

During the first year, did the child: eat well _____ gain weight normally_____ sleep well _____

Please indicate the age at which your child began:

Walking alone: _____ Using meaningful words: _____

Bowel control: _____ Bladder control: _____

Did your child experience difficulty in expressing his or her thoughts?

Did your child have trouble separating from you to start daycare/school? _____

At what age did he/she start daycare/school? _____

Please list the schools that your child has attended and his/her school performance and behavior at these schools.

School	Child's age	Performance	Behavior
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If you need more space, please go to back of page)

Please describe your child's bedtime routine. _____

_____

If there are siblings in the home, is this routine similar to sibling bedtime routines?

Child's Medical History

How is the general health of your child (please circle):

Good Fair Poor Very poor

When did a doctor last see your child? _____What was the reason for the visit? ____

Has the child ever had surgery for any of the following conditions (circle all that apply):

Tonsillitis Eye, ear, nose, throat Burns Adenoids Hernia

Digestive disorder Urinary Tract Leg or arm Appendicitis Other

Has the child ever had any accidents resulting in the following (circle all that apply):

Broken bones	Severe bruises	Sutures	Severe lacerations	
Stomach pumped	Lost teeth	Head injury	Eye injury	Other

Please circle any of the following that apply to your child:

Frequent colds	Hearing problems	Sexual abuse
Ear infections	Speech problems	Lead poisoning
Asthma	Visual problems	Head injury
Frequent headaches	Sleeping problems	Lack of energy
Physical abuse	Language problems	Seizures
Frequent worrying	Eating problems	Menstrual problems
Tics/twitches		

Describe any significant medication conditions, illnesses, accidents or operations that your child has experienced: _____

_____

_____

_____

Does your child have any diagnosed or suspected learning impairments? If yes, please specify _____

_____

_____

_____

Has your child been seen by a psychiatrist in the past? If yes please describe reason for visit: _____

Does your child have any diagnosed or suspected psychiatric illnesses or disorders? If yes, please explain _____

_____

_____

Child's Drug and Alcohol History (check all that apply – known or suspected)

Alcohol
Marijuana
Heroin
Cocaine
Crack
Amphetamines
Hallucinogens
Barbiturates
Quaaludes
Inhalants (e.g. sniffing glue, white out, sharpie pens, gasoline, inhaling aerosol cans such as whip cream or computer dusters). Have you observed extra cans lying around, whip creams that are flat, or excessive use of any of the above mentioned items?

_____

_____

Is your child taking medications prescribed by a physician or psychiatrist? _____

If so, please indicate type, amount, length of time taking the medication and any known side effects.

Medication	Amount	Length of time	Known side effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If your child is taking medications, do you feel they are helping? _____

What is your child's attitude toward taking medication? _____

Family History

When did the child's parents meet? _____

Did they marry? _____ If so, in what year did they marry? _____

Are they separated? _____ If so, what year did they separate? _____

Are they divorced? _____ If so, what year did they divorce? _____

If separated or divorced, what is the visitation arrangement? _____

Are there any problems with custody/visitation? If yes, please explain _____

How many times have you moved in your child's life? _____

Have any of these moves been out of town/county/state/country? _____

Have any of these moves been seemingly difficult or traumatic for your child? _____

How is your child's relationship with:

Mother _____

Father _____

Brothers _____

Sisters _____

Extended family (if applicable)_____

Other children _____

Other adults (e.g. teachers, etc.) _____

Is there any history of alcohol/substance abuse or mental illness in the child's family? If so, please describe nature of illness and person's relation to child. _____

Has your family ever been involved with DCF? If so, please explain. _____

_____

Current Behavior

What are your child's favorite activities (toys, hobbies, sports, etc.)?

_____

If there are siblings, how do they relate with each other? _____

_____

Does your child have peer friendships in school and at home? Any concerns with how your child socializes with peers? _____

_____

Are there significant extended family members with whom your child has a close relationship, e.g. cousins, aunts, uncles, grandparents. _____

_____

_____

Do you have any pets? _____ If so, what kind _____

How does your child interact with pets/animals _____

Does your child display behavior that is particularly stressful for you to handle?

_____

_____

_____

Has your child frequently been absent from school? (describe)

_____

_____

How much time does your child spend watching TV and playing video games each weekday/weekend? _____

How is your child disciplined? Do parents agree about discipline? _____

_____

If there are other children in the home, how are they disciplined? _____

Do any of your other children have a significant medical or mental illness or other impairment, e.g. learning, etc. _____

_____

Thank you for taking the time to complete this questionnaire.

Please feel free to attach additional pages if you have any questions or additional comments. We will discuss this questionnaire in more detail when we meet.