DEVELOPMENTAL HISTORY QUESTIONNAIRE

Name of child/teen: _____ Date: _____

Current Age: _____ Gender: **M** **F** DOB: _____

Name of the person complteing Quesntionnaire: _____

Relationship to child/teen: _____

MAJOR AREAS OF CONCERN

What is child's problem and when did it begin? _____

How have you tried to resolve the problem? What have you found to be effective? _____

Has your child been treated for this problem befpore? **YES / NO** By whom? _____

Results: _____

PREGNANCY

Were there complications or difficult life events during pregnancy? **YES** **NO**

If so, please describe: _____

Were any of the following substances used more than a few times by the birth mother during pregnancy?

☐ Beer or Wine ☐ Hard alcohol ☐ Coffee, tea, or caffeine drinks ☐ Cigarettes ☐ Marijuana

☐ Tranquilizers or Pain medications ☐ Antibiotics ☐ Anti-seizure medications ☐ Insulin

☐ Other prescription medications? Please specify: _____

☐ Other street drugs, please specify: _____

LABOR AND BIRTH

Please describe any problems during labor or delivery: _____

Duration of labor? _____ Birth Weight: _____

APGAR _____ Please describe any difficult adjustments for your baby after birth:

Please describe your experiences bonding with your infant: _____

SIGNIFICANT CAREGIVERS

Please describe the primary caregivers for your infant during the first three years:

Since then? _____

Please rate your child's functioning as an infant and toddler in the following areas:

Behavior	Advanced	Average	Delayed	Specific Problems
Feeding	☐	☐	☐	
Sleeping	☐	☐	☐	
Motor Development	☐	☐	☐	
Language Development	☐	☐	☐	
Relational Development	☐	☐	☐	

Was the child a cuddly baby? _____ Irritable baby? _____

Which best describes your child's development? (check one) ☐ Slow ☐ Fast ☐ Normal

What is your opinion of your child's intelligence? (check one) ☐ Average ☐ Below Average ☐ Above Average

Additional comments: _____

Has your child ever had… (check all that apply) ☐ Seizures or convulsions? ☐ Head injuries? ☐ Memory problems? ☐ Coordination problems?

FAMILY RELATIONSHIP HISTORY - Please describe your child's relationships with her/his parents, guardiangs, siblings, and extended family members. _____

Describe any mental heatlh problems, drug abuse, or alcoholism in immediate family and extended family.

Have either parent or any of the blood relatives had a problem similar to the child's? **YES / NO**
If so, please describe. _____

Please describe who currently lives in your household and their relationships to your child.

How does your child relate with each parent? _____

Which Parent does this child most resemble in terms of disposition? _____
Looks: _____ Attitude towards others: _____
How does father discipline this child? _____
How does mother discipline this child? _____
Which parent is most upset by this child's behavior? _____
Any contacts with police or Protective Service? **YES / NO** If yes, describe: _____

How often has family moved? _____

FAMILY BACKGROUND

Mother (or primary female caretaker, i.e. stepmother, grandmother, etc.):
Where did you grow up? _____
Ethnic, cultural, and religious background: _____

Names/ages of your brothers and sisters: _____

How did you get along with your parents and siblings as a child? How are these relationships now?

How much contact do you and your child have with your side of the family? _____

Father (or primary male caretaker, i.e. stepfather, grandfather, etc.):
Where did you grow up?
Ethnic, cultural, and religious background:

Names/ages of your brothers and sisters:

How did you get along with your parents and siblings as a child? How are these relationships now?

How much contact do you and your child have with your side of the family?

Family problems which may be affecting your child

Recent or multiple moves?
Parental separation or divorce?
Family violence?
Conflict between parents?
Drug or alcohol abuse?
Remarriage or new partner?
Custody dispute?
Financial stress?
Health problems?
Psychiatric illness?
Death in the family?
Absence of parent?

SOCIAL DEVELOPMENTAL HISTORY - Please describe family relationships with adults and children, peers, special friendships or attachments, pets, etc.

In what groups does child participate?
Any religious participation?
Does your child play primarily with children his/her own age? **YES / NO** **Younger / Older**

SOCIAL BEHAVIOR

Please explain any pertinent issues regarding your child's social behavior:

Does your child have particular sensitivities? (i.e. food, tags on clothing, etc.)?

SCHOOL HISTORY - Please describe how your child responded to beginning school, favorite subjects or activities, academic performance, any difficulties, notable changes in school functioning and the surrounding events.

Name of present school: Grade:
Is the child in Special Education/ARD meetings?
If yes, which service resources? Educational: Behavioral:
IEP: Alternative school: 504
Has the child ever repeated a grade? **Y / N** What grades?
How many schools has your child attended?

METHODS OF DISCIPLINE - Please describe ways you encourage changes in your child's behavior.

Has child ever been physically, sexually, or emotionally abused?

How does child feel about therapy?

SIGNIFICANT LOSSES OR TRAUMAS (for example, death, separations, divorce, illness, abuse, crime)
If any significant losses or trauma (refer above), how did your child react?

Does your child remind you of anyone in your family; of events or issues from your own childhood; of your birth order?

INTERESTS AND ACCOMPLISHMENTS
What are your child's main interests and hobbies?

What are your child's strengths and areas of greatest accomplishments?

PHYSICAL HEALTH List all past medications, for what problem, and how well they work.

Name	**Dose**	**Reason**	**How Long**	**Effectiveness**

Who prescribed the medications?

RELEVANT CONTACT PERSONS

In order to provide the most comprehensive mental health services possible, it is important to gather information from a wide variety of sources. This often includes having caregivers' permission to exchange information with teachers, physicians, past therapists, and others involved in the child's and family's life.

Please indicate below the names and contact information for the individuals or agencies who might be able to provide further relevant information. **This, however, does not allow us to contact these people.** This information will simply be used to complete formal release forms which, if you choose to sign, will then allow us to contact the individuals or agencies so designated.

SCHOOL or PLACE OF EMPLOYMENT:

Name of individual or agency and contact person, as appropriate: _____

Address: _____

Phone: ( ) - Fax: ( ) -

PEDIATRICIAN OR PHYSICIAN:

Name of individual or agency and contact person, as appropriate: _____

Address: _____

Phone: ( ) - Fax: ( ) -

FORMER THERAPIST:

Name of individual or agency and contact person, as appropriate: _____

Address: _____

Phone: ( ) - Fax: ( ) -

Signature of Parent or Guardian: _____

Date: _____