Clinic for Special Children

Developmental Questionnaire

Child's name: ....Sex: ❑ M ❑ F Date of Birth: ___/___/_____
Address: ....Phone: ....
City/State/Zip:..Cell:..
Person answering questions:..Relationship to patient: ....
Address (*if different*):...Phone: ....
City/State/Zip:..Cell:..
Why are you seeking help for this child?...
....
....
....
Who referred you to our service?..
What kind of services are you seeking for this child (eg: *diagnosis, medication management, change of school placement, therapy, psychological testing, custody, evaluation, etc*)?..
....
....
....
Mother's Name: ....Stepmother? ❑ Yes ❑ No
Address (*if different*):...Phone: ....
City/State/Zip:..Cell:..
Occupation:..Employer:..
Highest grade/degree completed:...
Father's Name:..Stepmother? ❑ Yes ❑ No
Address (*if different*):...Phone: ....
City/State/Zip:..Cell:..
Occupation:..Employer:..
Highest grade/degree completed:...
Does this child have any other parent(s) Stepparents(s)? ❑ Yes ❑ No
Address (*if different*):...Phone: ....
City/State/Zip:..Cell:..
Occupation:..Employer:..
Highest grade/degree completed:...
With what adults does this child live? ....
How long in current living situation? ....Child's primary caregiver? ....
If primary caregivers work outside the home, please provide the following information:
Who cares for this child when caregivers are gone?...
How many hours per day is this child in a child-care setting? ....
Has this child ever experienced any parental separations, divorces, or death? ❑ Yes ❑ No
If yes, when?..Child age at the time? ....
Please describe the circumstances: ....
If parents are separated or divorced who has custody of this child? ....
How often does the other parent see this child? ❑ Weekly or more often
❑ Once or twice a month ❑ Few times a year ❑ Never

Please list all brothers and sisters, and any other children living with the family:

Age	Gender	Relationship to this child	Living at home?

How does this child get along with brother(s) and /or sisters? ....

....

I. Family Relations

Check the activities in which this child often participates with the family:

❑ Movies ❑ Meals ❑ Conversations ❑ Visits with relatives
❑ Church ❑ Games ❑ Sports ❑ Trips ❑ Television
❑ Other..

How frequently does this child see grandparents?

❑ Weekly or more often ❑ Once or twice a month ❑ Few times a year ❑ Never
No grandparents living ❑ Yes ❑ No
What do you find most difficult about raising this child? ....

....

....

What would you like this child to be when he/she grows up?..

....

What level of education do you hope this child will complete?
❑ High School ❑ College ❑ Technical or vocational school

Who is mainly in charge of discipline in the home?..

Do all caregivers agree on discipline? ....

Describe discipline techniques:..

....

....

Friendship

Please indicate how this child relates to other children.

Has problems relating to our playing with other children? ❑ No ❑ Yes
If yes, describe: ....
Fights frequently with playmates ❑ No ❑ Yes
Prefers playing with younger children ❑ No ❑ Yes
Has difficulty making friends ❑ No ❑ Yes
Prefers to play alone ❑ No ❑ Yes
Are there children in the neighborhood with whom this child could play? ❑ No ❑ Yes
What role does this child take in peer group games (for example: aggressor, leader, victim, etc)?

....

Recreation / Interests

What activities does this child enjoy?

Sports: ....

Hobbies: ....

Other: ....

Has this child's interest in participating in these activities declined recently? ❑ No ❑ Yes

If yes, describe: ....

Behavior / Temperament

Please indicate whether this child exhibits any of the following behaviors:

Is easily over stimulated in play: ❑ No ❑ Yes
Seems overly energetic in play: ❑ No ❑ Yes
Has a short attention span: ❑ No ❑ Yes
Seems impulsive: ❑ No ❑ Yes
Lacks self-control: ❑ No ❑ Yes
Overreacts when facing problems: ❑ No ❑ Yes
Seems unhappy most of the time: ❑ No ❑ Yes
Uncomfortable meeting new people: ❑ No ❑ Yes
Hides feelings: ❑ No ❑ Yes
Requires a lot of parental attention: ❑ No ❑ Yes
Withholds affection: ❑ No ❑ Yes
What makes this child angry? ....
Has fears: ❑ No ❑ Yes
Describe: ....

....

Adaptive Skills

Please indicate whether this child has the following skills:

Dresses self: ❑ No ❑ Yes
Bathes self: ❑ No ❑ Yes
Helps with household chores: ❑ No ❑ Yes
Has good table manners: ❑ No ❑ Yes
Buys gifts or presents for others ❑ No ❑ Yes
Can get help or find home if lost: ❑ No ❑ Yes
Says "please" and "thank you" ❑ No ❑ Yes
Tells time accurately: ❑ No ❑ Yes
Receive an allowance: ❑ No ❑ Yes
If yes, how does he/she spend it? ....

....

II. Educational History

Preschool

Does or did this child attend preschool? No Yes
At what age? ....

School: ....
Teacher: ....

Amount of time per day: ....
Days per week: ....

Elementary / High School

Please indicate whether this child has had any of the following school experiences:

Has changed schools for reasons other than normal academic progression? ❑ No ❑ Yes

Has repeated a grade? ❑ No ❑ Yes If yes, when and why? ....

....

Has skipped a grade in school? ❑ No ❑ Yes If yes, when and why? ....

....

Has difficulty with reading? ❑ No ❑ Yes If yes, describe: ....

....

Has difficulty with math? ❑ No ❑ Yes If yes, describe: ....

....

Gets poor grades? ❑ No ❑ Yes

Describe most recent report card results: ....

Been tested for special education? ❑ No ❑ Yes If yes, when ....

Currently in special education class? ❑ No ❑ Yes

If yes, what type of class? .... Hours per day: ....
Other services (OT, SpT, PT) ❑ No ❑ Yes Which? ....
Date of last revised IEP: ....
Dislikes going to school? ❑ No ❑ Yes
Is absent from school frequently? ❑ No ❑ Yes If yes, why? ....
If in high school, when will this child graduate? ....
Do you have any concerns about the quality of this child's school or teachers? ❑ No ❑ Yes
If yes, describe: ....

III. Development

At what age did this child first do the following? Indicate age / year / month.

Turn over: .... Sit alone: ....
Crawl: .... Stand alone: ....
Walk alone: .... Walk up stairs: ....
Walk down stairs: .... Show interest in or attraction to sound: ....
Understand first words: .... Speak first words: ....
Speak in sentences: ....
Was this child breast-fed? ❑ No ❑ Yes When weaned? ....
Was this child bottle-fed? ❑ No ❑ Yes When weaned? ....
When was this child toilet trained? Days: .... Nights: ....

Has this child experienced any of the following problems? If yes, please describe.

Walking difficulty ❑ No ❑ Yes ....
Unclear speech ❑ No ❑ Yes ....
Feeding problem ❑ No ❑ Yes ....
Underweight problem ❑ No ❑ Yes ....
Overweight problem ❑ No ❑ Yes ....
Colic ❑ No ❑ Yes ....
Sleep problem ❑ No ❑ Yes ....
Difficulty with sleep onset ❑ No ❑ Yes Difficulty with sustained sleep? ❑ No ❑ Yes
Duration of sleep? ❑ No ❑ Yes Sleep schedule? ....
Difficulty learning to ride bike ❑ No ❑ Yes ....
Eating disorder ❑ No ❑ Yes ....
Learning to skip ❑ No ❑ Yes ....
Learning to throw/catch ❑ No ❑ Yes ....

During this child's first 4 years, were any special problems noted in the following areas?
If yes, please describe.

Eating ❑ No ❑ Yes ....
Motor skills ❑ No ❑ Yes ....
Sleeping too much ❑ No ❑ Yes ....
Temper tantrums ❑ No ❑ Yes ....
Sleeping to little ❑ No ❑ Yes ....
Failure to thrive ❑ No ❑ Yes ....
Separating from parents ❑ No ❑ Yes ....
Excessive crying ❑ No ❑ Yes ....
Other (throwing, etc)? ❑ No ❑ Yes ....

Has this child been forced to change writing hand? ❑ No ❑ Yes

IV. Pregnancy

Was this child a planned pregnancy? ❑ No ❑ Yes Was the mother under a doctor's care? ❑ No ❑ Yes
Number of previous pregnancies / miscarriages:..................
Check any of the following complications that occurred during the pregnancy.

❑ Difficulty in conception ❑ Emotional problems ❑ Anemia
❑ Excessive swelling ❑ Toxemia ❑ Flu
❑ Abnormal weight gain ❑ Vaginal bleeding ❑ High blood pressure
❑ Other (Rh incompatibility, vaccines, fillings, etc.) ....

Maternal injury: ❑ No ❑ Yes Describe: ....
Hospitalization during preg.: ❑ No ❑ Yes Reason..
Medications during pregnancy: ❑ No ❑ Yes Frequency ....
Cigarettes during pregnancy: ❑ No ❑ Yes Frequency..
Other drugs used during pregnancy: ❑ No ❑ Yes Type ....
Frequency..
At this child's birth, what was the mother's age?....................... Father's age?....................................
Mother's age at birth of first child? ....
Was this child born in the hospital? ❑ No ❑ Yes If no, where? ....
Length of pregnancy ....weeks Length of labor.........................hours
Birth weight: ....lbs............... ozs
Apgar score .... Child's condition at birth ....
Mother's condition at birth ....
Check any of the following complications that occurred during birth.

❑ Forceps used ❑ Breech birth ❑ Labor induced ❑ Caesarean delivery

Other deliver complications: ❑ No ❑ Yes Describe ....
....
Incubator: ❑ No ❑ Yes How long?..
Jaundiced: ❑ No ❑ Yes
Bilirubin lights: ❑ No ❑ Yes If yes, how long?..
Breathing problems right after birth: ❑ No ❑ Yes If yes, how long?...
Anesthesia used during delivery: ❑ No ❑ Yes If yes, what kind?...
Length of stay in hospital: Mother........................... days Child.................................... days

V. Medical History

Childhood illnesses / injuries:
Please circle the illnesses this child has had an indicate age (year/month).

❑ Chicken pox.. ❑ Scarlet fever..
❑ Rheumatic fever .... ❑ Meningitis...
❑ Encephalitis .... ❑ Anemia ....
❑ Fever above 104°....................................

Head injury: ❑ No ❑ Yes Describe ....
Coma or loss of consciousness: ❑ No ❑ Yes Describe ....
Sustained high fever: ❑ No ❑ Yes Describe ....
Please describe other serious illnesses or operations:

Illnesses/Operations	Age	Illness/Operation	Age
....		....	
....		....	

Has this child ever been on long-term medications (more than 6 months)? ❑ No ❑ Yes
If yes, when... What kind?..
If yes, when... What kind?..

Respiratory

Please indicate whether this child currently has any of the following problems. If yes, describe how often.

- Frequent colds: ❑ No ❑ Yes...
- Asthma: ❑ No ❑ Yes...
- Sinus condition: ❑ No ❑ Yes...
- Chronic cough: ❑ No ❑ Yes...
- Hay fever: ❑ No ❑ Yes...

Cardiovascular

If yes, please describe:

- Shortness of breath or dizziness with physical exertion: ❑ No ❑ Yes..
- Activity limitation due to heart condition: ❑ No ❑ Yes..
- Heart murmur: ❑ No ❑ Yes...

Gastrointestinal

Excessive vomiting: ❑ No ❑ Yes...

Frequent diarrhea: ❑ No ❑ Yes...

Constipation: ❑ No ❑ Yes...

Describe stool and pattern of elimination: ....

Stomach pain: ❑ No ❑ Yes...

Reflux/heart burn: ❑ No ❑ Yes...

Dietary history:

Food sensitivities? ❑ No ❑ Yes...

Food cravings? ❑ No ❑ Yes...

Food aversions? ❑ No ❑ Yes...

List foods most commonly eaten: ....

Genitourinary

Urination in pants/bed: ❑ No ❑ Yes...

Pain while urinating: ❑ No ❑ Yes...

Excessive urination: ❑ No ❑ Yes...

Strong odor to urine: ❑ No ❑ Yes...

Musculoskeletal

Muscle pain: ❑ No ❑ Yes...

Clumsy walk: ❑ No ❑ Yes...

Poor posture: ❑ No ❑ Yes...

Other muscle problems? ❑ No ❑ Yes Describe ....

Skin

Frequent rashes: ❑ No ❑ Yes...

Bruises easily: ❑ No ❑ Yes...

Sores: ❑ No ❑ Yes Describe ....

Severe acne: ❑ No ❑ Yes...

Itchy skin (eczema): ❑ No ❑ Yes...

Irregular skin flushing: ❑ No ❑ Yes Describe ....

Fever blisters: ❑ No ❑ Yes...

Neurological

Seizures/convulsions: ❑ No ❑ Yes Describe ....

Speech defects: ❑ No ❑ Yes...

Accident prone: ❑ No ❑ Yes...

Bites nails: ❑ No ❑ Yes...

Sucks thumb: ❑ No ❑ Yes..
Grinds teeth: ❑ No ❑ Yes..
Has tics / twitches: ❑ No ❑ Yes..
Bangs heard: ❑ No ❑ Yes..
Rocks back and forth: ❑ No ❑ Yes..
Toe walking: ❑ No ❑ Yes When? ....
Self-injury: ❑ No ❑ Yes How? ....
Bowel movements in pants/bed: ❑ No ❑ Yes..
Has this child ever taken medication to increase activity? ❑ No ❑ Yes...
If yes, when? .... What medication: ....
Has child ever taken tranquilizing medication? ❑ No ❑ Yes
If yes, when? .... What medication: ....
Brain scan obtained? ❑ No ❑ Yes..
Brain wave study (EEG) obtained? ❑ No ❑ Yes..

Allergies

Allergy to medicine: ❑ No ❑ Yes Describe ....
Allergy to food: ❑ No ❑ Yes Describe ....
Other allergies: ❑ No ❑ Yes Describe ....
Adverse reactions to vaccines? ❑ No ❑ Yes Describe ....

Hearing

Ear infections: ❑ No ❑ Yes Describe ....
Hearing problems: ❑ No ❑ Yes Describe ....
Ear tubes: ❑ No ❑ Yes Describe ....
Date Of Most Recent Hearing Exam: ....

Vision

Vision problems: ❑ No ❑ Yes Describe ....
Wears glasses/contacts: ❑ No ❑ Yes
Date of most recent vision exam:..

Medical Care

Child's Physician: ....
Telephone:.. Fax: ....
Address: ....
How often does this child see a doctor: .... Date of last visit: ....
Child currently on medication? ❑ No ❑ Yes
If yes, indicate type and reason: ....
....
....
....
List nutritional supplements, if any:
....
....
Has this child ever had psychological counseling or therapy? ❑ No ❑ Yes
If yes, counselor's name ....
Telephone:.. Fax: ....
Address: ....
Type of counseling..
When? ....

Has this child ever had a neurological exam? ❑ No ❑ Yes
If yes, neurologist's name ....
Address ....
Date of exam ....
Reason ....

Has this child ever had a psychological or psychiatric exam? ❑ No ❑ Yes
If yes, doctor's name ....
Address ....
Reason for exam ....

VI. Family Health

Has any family member had any of the following? *If yes Please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.*

- ❑ Cancer ....
- ❑ Cystic fibrosis ....
- ❑ Diabetes ....
- ❑ Heart disease ....
- ❑ High blood pressure ....
- ❑ Kidney disease ....
- ❑ Migraine headaches ....
- ❑ Multiple sclerosis ....
- ❑ Physical handicap ....
- ❑ Stroke ....
- ❑ Tuberculosis ....
- ❑ Alzheimer's disease ....
- ❑ Hemophilia ....
- ❑ Huntington's chorea ....
- ❑ Muscular dystrophy ....
- ❑ Parkinson's disease ....
- ❑ Sickle-cell anemia ....
- ❑ Tay-Sachs disease ....
- ❑ Tourette's syndrome ....
- ❑ Birth defect ....
- ❑ Cerebral palsy ....
- ❑ Alcohol / drug abuse ....
- ❑ Behavior disorder ....
- ❑ Emotional disturbance ....
- ❑ Mental illness ....
- ❑ Mental retardation ....
- ❑ Nervousness ....
- ❑ Seizures or epilepsy ....
- ❑ Reading problem ....
- ❑ Other learning disability ....
- ❑ Speech or language problem ....
- ❑ Food allergies/hayfever ....
- ❑ Severe head injury ....
- ❑ Other: Describe ....

....

Describe father's present health ....
Describe mother's present health ....
Has anyone in the family ever been in special education? ....
If yes, who? ....
What type of class? ....

Additional Comments

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....
....
....
....

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