DEVELOPMENTAL QUESTIONNAIRE

Please be as detailed as possible

CHILD'S NAME: _____ DATE OF BIRTH: _____

DATE OF EVALUATION: _____ AGE: _____ GRADE: _____

Person Completing Questionnaire: _____

Home Address:_____

Phone Numbers: (home) _____ (work/cell)_____

Is this child adopted or a foster child? Yes / No

Are parents married? Yes / No **Divorced?** Yes / No

If divorced or separated, who has legal custody of the child? _____
(*In the case of joint custody following divorce, all parents/guardians with legal custody must sign forms consenting to the evaluation*.)

Name of Pediatrician or Referring Provider: _____

Chief problem or concern: _____

Please describe child's strengths: _____

Please describe child's weaknesses: _____

_____

_____

Are there behavioral problems at home or school? _____

_____

_____

Has child been previously evaluated? (list dates and evaluators) _____

_____

What were the results/recommendations? _____

_____

FAMILY HISTORY

List people currently in child's current household (include gender and age): _____

_____

_____

What language is spoken at home? _____

Mother's Education: _____ Occupation: _____

Father's Education: _____ Occupation: _____

Please list family members/relatives who are left-handed or ambidextrous: _____

_____

Please list family members/relatives with academic problems (e.g. reading, mathematics, spelling) and the types of problems:

Please list family members/relatives with behavioral problems (e.g. overactive, withdrawn, legal trouble, aggressive behavior, etc.):

Please list family members/relatives with psychiatric problems (e.g. depression, bi-polar disorder, anxiety, schizophrenia, etc.):

Please list family members/relatives with neurological problems (e.g. seizures, Attention Deficit / Hyperactivity Disorder, genetic conditions, Autism, etc.):

BIRTH HISTORY

Did you or your doctor note any problems with your pregnancy? _____

_____

Labor? _____ Delivery? _____

Age of Mother at Delivery? _____ Age of Father? _____

Was this child full-term (born at expected time?) _____

Birthweight: _____ Condition At Birth? _____

Jaundice, "Rh" problems, meconium stain, "blue"? _____

Feeding Problems? _____

Sleeping Problems? _____

Was this child fussy as an infant? _____ Did child respond to cuddling or other soothing?

_____

Any other problems as an infant? _____

_____

DEVELOPMENTAL HISTORY

Compared to other children, did this child have difficulty:

Learning to talk? _____ To understand? _____

Gross Motor Skills (walking, hopping, running)? _____

Fine Motor Skills (buttons, zippers, drawing)? _____

Early School Skills (colors, counting, alphabet)? _____

Sitting still (for TV or stories)? _____

Playing/Socializing (with other children)? _____

When was child weaned and how did s/he respond to this process?

Approximate age when child:

sat alone	_____	stood alone	_____
crawled/crept	_____	pulled to stand	_____
walked	_____	babbled	_____
said first word	_____	first 2-3 word combination	_____
fed self	_____	dressed self	_____

Compared to other children, did this child have difficulty:

Toilet Training – daytime? _____ nighttime? _____

At what age did this child show hand preference? _____ Which hand? _____

Does this child play with older, younger or same age children? _____

ABOUT YOUR CHILD

Is there a history or current sensory-based concerns (e.g., tactile, loud noises, tastes, etc.)?

How would you describe your child's relationships/interactions with his/her peers?

How would you characterize your child's relationship(s) with her/his sibling(s)?

What is your child's relationship like with you?

What are your child's favorite activities?

What are your child's least favorite activities?

In what after-school activities does s/he participate?

MEDICAL HISTORY

Does this child have any medical problems? _____

_____

History of seizures/convulsions? _____

Serious Illnesses? _____

Operations? _____

Other Hospitalizations? _____

Allergies? _____

Head Injury? _____ Was the child unconscious? _____ dizzy? _____ headache? _____

Prior Genetic Testing? _____

Abdominal pains/vomiting? _____

Headaches? _____

Ear Infections? _____

Visual Problems? _____

Is the child currently on any medications and, if so, what medications, current dose for each, and who is the prescriber (please list):

_____

Has this child ever received behavioral intervention, ABA, therapeutic counseling?

_____

If yes, by who, between what dates, and why? _____

_____

SCHOOL HISTORY

Present Grade: _____ Has child repeated a grade? _____

Name of School: _____

School Address: _____

School Contact Person: _____ Phone Number: _____

May I contact this person regarding your child's schoolwork? _____

Did this child attend preschool? _____

When did school problems become evident? _____

Has your child been evaluated for special educational services, accommodations, or an Individualized Education Plan (IEP) or 504 Plan through the school?_____

_____

Specific Interventions: _____

_____

_____

Does your child enjoy school? _____

On ***an average school day***, how much time does your child spend:

Doing Homework? _____ Alone? _____ With your help? _____

Socializing with Peers? _____ with family members?_____ other adults? _____

Watching TV? _____ Using Computer (non-academic activity)? _____

Reading for Pleasure (or being read to)? _____

EVALUATION QUESTIONS

Who suggested you get this evaluation? _____

What do you hope to gain from this evaluation? _____

_____

_____ _____

Signature Date

If your child is school age, please also bring any school reports you have when you come for the evaluation.

This includes:

- Report cards; Teacher reports
- Individualized Education Plan, 504 Plan, and/or a the most recent progress report
- Medical records or Early Intervention Services discharge reports
- Standardized test results from any previous evaluations: Cognitive (IQ), Achievement, Adaptive, etc.

Thank you very much for taking the time to complete this questionnaire. Please feel free to note any other concerns on the reverse side of this form