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DEVELOPMENTAL/MEDICAL QUESTIONNAIRE

Your kindness in furnishing the following information will be appreciated. This information will be used in strict confidence to assist in evaluating and/or treating your child.

Today's Date:

GENERAL INFORMATION

Client's Name:
Birth Date:
Age:_____Yrs._____Mos. Sex: Male ____ Female_____
Phone:
Street Address:
City: State: Zip Code:

Living With:_____ Both Parents _____Mother _____Father _____Other
Step-parents involved:
Custodial Parent:
Mother: Marital Status:
Employer/Occupation:
Cell Phone:
Email:

Father: Marital Status:
Employer/Occupation:
Cell Phone:
E-mail:

List brothers and sisters of the child:

Name	Age	Sex	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any other persons live in your home? YES_____ NO_____If YES, who?

Other Professionals:
Teacher Name:
Teacher Email:

Pediatrician/Family Physician:
Do you want results faxed to your child's physician?
If so, Fax #:

May I have permission to have contact with your child's teacher?
May I have permission to have contact with your child's physician?
If yes to either of the above:

Signature
Date

Source of referral:

REASON FOR REFERRAL/CONCERNS/QUESTIONS:

1.

2.

3.

FAMILY HISTORY

Has there been a history of learning difficulties:

Mother: YES_____ NO_____ If YES, please describe:

Father: YES_____ NO_____ If YES, please describe:

Have any of the child's blood relatives experienced any of the following? If yes, what is their relationship to the child?

Learning Difficulties (Reading, Writing, Math)	YES_____ NO_____
Attention Deficit Hyperactivity Disorder (with or without hyperactivity)	YES_____ NO_____
Emotional Problems (i.e., Anxiety, Depression, Schizophrenia)	YES_____ NO_____
Seizures	YES_____ NO_____
Other developmental disabilities such as Autism,	YES_____ NO_____
Mental Retardation, …	

MEDICAL/DEVELOPMENTAL HISTORY

PRENATAL

Was prenatal care provided? YES_____ NO_____ If YES, at what month of pregnancy?_____

Were medication, alcohol, drugs, and/or tobacco used during pregnancy? YES_____ NO____

If YES, please explain:

If YES, please state what was used:

How much:

How long:

Any infections? YES_____ NO_____ If YES, please explain:

PREGNANCY

_____Full Term (40 Weeks)

_____Premature: How early?

_____Late: How late?

_____Complications? (Toxemia, Premature Labor,…)

DELIVERY

Labor:	_____Natural	_____Induce	_____Duration (Hours)
Type:	_____Vertex (Normal)	_____Breech	_____Cesarean

Birth Weight: _____lbs._____oz.

COMPLICATIONS

At birth:

_____Cord around neck _____Hemorrhage (Excessive Bleeding)

_____Cord presented first _____Infant injured during delivery

_____Other:

After delivery:

_____Intensive Care _____Jaundice _____Oxygen Used

_____Infection _____Transfusion _____Cyanosis(turned blue)

_____Other:

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age, the incident or illness occurred, and any other pertinent information.

	Age	*Incident/Illness*	*Other Information*
Childhood Illness	_____	_____	_____
Hospitalizations/Surgeries	_____	_____	_____
Head Injuries	_____	_____	_____
Loss of Consciousness	_____	_____	_____
Seizures	_____	_____	
Hearing Problems	_____	_____	
Persistent High Fevers	_____	_____	
Ear Infections	_____	_____	
Allergies	_____	_____	
Medications	_____	_____	
Glasses	_____	_____	

How are your child's sleep and appetite?

Other significant medical history:

DEVELOPMENTAL MILESTONES (please circle)

Speech/language development	delayed	on time	advanced
Gross-motor development	delayed	on time	advanced
Fine-motor development	delayed	on time	advanced
Social development	delayed	on time	advanced
Emotional development	delayed	on time	advanced

If developmental milestones were delayed, please explain:

THERAPY HISTORY

(It is helpful to have reports and evaluations from other professionals you have worked with in the past at the initial parent interview)

Has your child ever participated in mental health related therapy? YES_____ NO_____

If yes, date of service: With Whom?

Purpose:

Has your child ever completed psychological testing (LD, ADHD, anxiety, etc?) YES _____ NO_____

If so, date of evaluation: With Whom?

Results:

Has your child ever taken psychiatric medication? YES_____ NO_____

If yes, current medication:

Past medication:

Has your child ever participated in any other therapies, such as occupational therapy, speech/language therapy, or vision therapy? YES_____ NO_____
If yes, date(s) of service(s) and purpose:

ACADEMIC HISTORY

Current School:
Grade:

Previous School(s):

Are you planning on switching schools anytime soon? If so, to which school?

Has your child repeated any grade(s)? YES_____NO_____; If yes, which one(s)?

Do your child's grades in school vary dramatically from day to day? YES_____ NO_____

Are there any specific subjects that tend to be harder and/or easier for your child? If so, which?

Currently, what is your child's grade in school, primarily?
____A & B ____B & C ____C & D ____D & F

Does your child receive any special education assistance (such as through IEP or 504 Accommodation Plan)? YES_____ NO_____
If yes, what type and what services are offered?

How does your child's teacher describe him/her?

School Behavior/Difficulties:

Does not do homework	Disorganized/Poor Planning
Poor handwriting	Poor attention/Distracted
Does not remain seated	Poor spelling
Non-compliant	Poor reading
Test anxiety	Poor math skills
Forgets assignments/Forgets to turn in	Problems with written language
Takes excessive time to complete	Poor note taking

SOCIAL DEVELOPMENT

Does your child play successfully with children of all ages, primarily older children, or primarily younger children?

Does your child experience any problems with peers? YES_____ NO_____

If yes, please explain:

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Please check those you believe your child exhibits to an excessive or exaggerated degree when compared to other children his/her age:

___Hyperactivity
___Acts as though "driven by a motor"
___Doesn't learn from experience
___Plays by him/herself during free time
___Doesn't listen when spoken to
___Impulsive
___Destroys toys
___Interrupts frequently
___More active than siblings
___Low frustration threshold
___Excessive number of accidents
___Sudden outbursts of aggression
___Needs to be entertained during free time
___Poor attention span
___Heedless to danger
___Temper outbursts
___Poor memory

EMOTIONAL DEVELOPMENT:

Does your child experience any anxiety and/or depression? Does your child overwhelm easily or have a low frustration tolerance? If so, please explain.

INTERESTS & ACCOMPLISHMENTS

What does your child enjoy doing most?

What does your child dislike most?

OTHER FACTORS

Describe any factors not covered in this form that you think are important for understanding your child: