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DEVELOPMENTAL QUESTIONNAIRE

Child's Name _____ Age _____ Birthdate _____ Sex ___

School _____ Grade _____ Ethnicity _____

Adopted Foster Care Ward or Dependent of Court Since what age? _____

Primary Language _____ Secondary Language _____

I. HISTORY OF CHILD'S PROBLEM

A. In your own words, describe the problem or condition for which you are seeking treatment for your child:

_____

_____

_____

_____

B. What methods were used in trying to help with these difficulties? Describe:

_____

_____

_____

C. In what way do you think I can help you? _____

_____

_____

_____

II. OTHER PROBLEMS

Does your child have any other problems that you feel are relevant (for instance, substance abuse, peer problems)? _____

_____

_____

_____

III. MENTAL HEALTH HISTORY

Has your child ever seen a therapist or counselor before? Yes No

If yes,

When and for how long? _____

Name of clinic or clinician that/who provided the treatment _____

_____

Type(s) of treatment (for example, individual therapy, group therapy, family therapy)____

_____

Were you and your child satisfied with the treatment? _____

Was medication prescribed? Yes No

If yes, what was dosage, was the medication effective, and were there side effects? _____

_____

_____

_____

IV. MEDICAL HISTORY OF THE CHILD

Has the child ever had any serious illnesses, accidents, or operations? Yes No

Please describe each incident and specify child's age (include any present illnesses):

_____

_____

_____

Is child allergic to any foods, medications, pollens, dust, or other substances? Yes No

Describe: _____

Doctor's name _____

Address _____

Phone Number _____ Date of last physical _____

Currently on medication? Yes No If yes, what? _____

Dosage? _____

Date started _____How often given? _____

Do you consider your child to be a healthy child most of the time? Yes No

Does your child wear/need glasses? Yes No

Does your child have/need braces? Yes No

IV. CHILD'S DEVELOPMENTAL HISTORY

A. PERIOD DURING PREGNANCY

Was the child planned? Yes No

How did mother feel about having the child? _____ Sex preference _____

Did the mother have any medical or emotional problems during pregnancy (for example, convulsions, hemorrhages, infection, unusual nervousness): _____

_____

_____

_____

_____

How did father feel about having this child? _____ Sex preference _____

Did the mother work during pregnancy? Yes No How long? _____

Did mother use alcohol, cigarettes, drugs? If yes, specify? _____

B. DETAILS OF DELIVERY, QUESTIONS ABOUT LABOR

Where was baby born? _____

How old was the mother? _____ How old was the father? _____

Were the mother and father married? Yes No

Type of delivery _____

Duration of labor _____

Were there any complications of labor and delivery? Please describe: _____

_____

_____

_____

_____

Did the mother have any "blues" after baby's birth? _____

C. POSTNATAL

Weight of baby at birth? _____ Was the baby full term (9 months)? Yes No

Were there any complications after the baby was born (for example, difficulty breathing, baby cyanotic [blue], R.H. Factor, baby jaundice)? _____

_____

Did the mother have any help in home after delivery? Yes No

If yes, how long? _____

During the baby's first year of life, was there anything (even if it had nothing to do with the baby) that caused the mother unhappiness or anxiety or that placed her under special strain? Describe: _____

_____

After baby's birth, how soon did mother return to work? _____

If mother was working, who had primary caretaking responsibility? _____

Was the child ever separated from both parents? Yes No

one parent? Yes No

Describe the circumstances (reason, child's age at time, and how long?): _____

_____

_____

_____

Did the father take an active part in the baby's care (such as changing diapers, bathing, feeding, etc.)? Yes No

D. FEEDING

Breast-fed How long? _____ Bottle-fed How long? _____

Were there any feeding problems (colic, diarrhea, or food allergies)? If so, explain:

_____

_____

When was the child weaned? _____ Why did weaning occur at that time? _____

How was child's discomfort handled? _____

Any thumb-sucking? Yes No Describe: _____

_____

E. SLEEPING PATTERNS

Were there sleeping problems? Yes No Describe: _____

_____

_____

Has the child ever slept with the parents? Yes No Describe circumstances:

_____

Present sleeping arrangements: _____

_____

F. MOTOR DEVELOPMENT

Was your child ever too active or too quiet? Yes No Describe: _____

_____

At what age did your child start: Sitting _____ Crawling _____ Walking _____

Who took primary responsibility for toilet training? _____

At what age was bowel training begun? _____ Completed _____

Method used: _____

_____

At what age was bladder training begun? _____ Completed for day? _____

Completed for night? _____ Method used: _____

_____

Was your child's toilet training ever a problem? Yes No If yes, describe how:

_____

Is this a problem at present? Yes No Describe: _____

_____

Is the child primarily right-handed? left-handed?

G. SPEECH DEVELOPMENT

Languages spoken in home _____

At what age did child first begin to speak in short sentences? _____

If there have been any of the following speech difficulties, please check:

Does not talk	Lisping
Delayed speech	Repeating syllables
Mispronouncing words	Stuttering

Other, describe: _____

_____

Has child ever had any speech therapy? Yes No

H. SEXUAL DEVELOPMENT

Has the child expressed curiosity about any sexual matters to a parent? Yes No

About what? _____

Has the child been given information by a parent in any of the following areas?

If yes, please check:

The difference between boys and girls	Menstruation
Birth control	Masturbation
How a woman becomes pregnant	Wet dreams
How the baby develops and is born	Intercourse

Other concerns of the parent _____

_____

I. PEERS AND INTERESTS

Does your child have any difficulty making friends? Yes No

Describe: _____

_____

Does he/she make friends primarily with children his/her own age? Yes No

Children younger? Older children? Adults?

Describe any special interests or hobbies: _____

_____

VI. SCHOOL INFORMATION

Did child attend pre-school? Yes No Beginning at what age? _____

Were there any problems? Yes No Describe: _____

_____

_____

Name of current teacher: _____

List all the schools your child has attended: _____

_____

_____

_____

_____

Does child have behavior, attitude, or attendance problems now in school? Describe: _____

_____

_____

_____

Does child have learning problems in school? Describe: _____

_____

_____

_____

If the child has ever been kept back or put ahead in school, explain: _____

_____

_____

If the child has been in special classes, what were reasons? Provide IEP history, if relevant _____

_____

_____

_____

Since what age? _____

If the child has ever been excluded from school, explain when and why? _____

_____

_____

Has your child had an AB3632 evaluation? Yes No

VII. JUVIENILE COURT HISTORY

Any arrests, offenses, probation, incarceration, placements? Yes No Describe: _____

_____

_____

If the child is on probation, who is the Probation Officer (name and phone): _____

_____

VIII. CHILD ABUSE AND PROTECTIVE SERVICES HISTORY

Has child ever been a victim of abuse? Yes No Explain: _____

_____

_____

_____

Age of occurrence _____ Offender _____

Children's Protective Services or Police Intervention? Yes No

Are any other agencies involved with the family (Dept. of Children and Family Services, Child Welfare)? _____

_____

_____

IX. FAMILY HISTORY

Mother's Name _____ Age _____

Occupation _____ Education _____

Number of marriages _____

Any significant medical problems? Yes No

If yes, please describe _____

_____

_____

Any serious illnesses, accidents or surgeries in the past? _____

_____

Any present or previous psychiatric treatment or counseling? Yes No

If yes, reason for treatment and how long ago _____

_____

_____

Any history of substance abuse (drug or alcohol)? Yes No Explain: _____

_____

Father's Name _____ Age _____

Occupation _____ Education _____

Number of marriages _____

Any significant medical problems? Yes No

If yes, please describe _____

_____

_____

Any serious illnesses, accidents or surgeries in the past? _____

_____

Any present or previous psychiatric treatment or counseling? Yes No

If yes, reason for treatment and how long ago _____

_____

_____

Any history of substance abuse (drug or alcohol)? Yes No Explain: _____

_____

_____

Siblings: _____ Age _____

_____ Age _____

_____ Age _____

Stepparent or guardian name _____ Age _____

Relationship _____ Occupation _____

Any significant medical problems? Yes No

If yes, please describe _____

_____

_____

Any serious illnesses, accidents or surgeries in the past? _____

_____

Any present or previous psychiatric treatment or counseling? Yes No

If yes, reason for treatment and how long ago _____

_____

_____

Stepparent or guardian name _____ Age _____

Relationship _____ Occupation _____

Any significant medical problems? Yes No

If yes, please describe _____

_____

_____

Any serious illnesses, accidents or surgeries in the past? _____

_____

Any present or previous psychiatric treatment or counseling? Yes No

If yes, reason for treatment and how long ago _____

_____

_____

Marital status of parents

Currently together Separated Divorced Widowed Single

Date of present marriage _____

Date of separation _____ or divorce _____

Who has legal custody? _____

Primary physical custody? _____

If child is not with natural parents, when and why did separation occur? _____

_____

_____

What type of living quarters (house, duplex, apartment, etc)? _____

Are all of your children currently living with you? Yes No

If not, specify: With whom they are living? _____

Reason they are living there _____

Are any of your children, whether or not they are living with you, under the jurisdiction of the juvenile court of Department of Children and Family Services (wards of the court, dependents of the court)?

_____

Has there been any recent changes in the family group? Yes No Who is involved in the change? _____

Divorce Date: _____

Separation Date: _____

Death of a family member Date: _____

Sharing the home with relatives or friends? Date: _____

If so, who _____

Frequent changes of residence? Date of last move: _____

Prolonged illness or absence of either parent? _____

Who usually cares for your child when parents are unavailable to do so? _____

_____

Do you have any questions, comments on the questionnaire, or additional information? _____

_____

_____

_____ _____

Parent/Guardian Parent/Guardian

Date: _____