



CHILD DEVELOPMENT HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Child's Name: _____	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
Previous or referring doctor: _____	Date of Last Developmental Exam: _____	

FAMILY STRUCTURE

Mother's/Guardian's Name _____ **Age** _____ Living with child Not living with child

Employment _____ **Occupation** _____ **Employed currently?** Yes No

Father's/Guardian's Name _____ **Age** _____ Living with child Not living with child

Employment _____ **Occupation** _____ **Employed currently?** Yes No

Parents are () Single Married Partnered Separated Divorced Widowed Other _____

If child is not living with parent(s), please explain circumstances: _____

Who are the members of your child's family/household?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there anything else you would like use to know or be aware of with regards to your child's family?

PREGNANCY & BIRTH HISTORY

Is your child adopted? Yes At what age? _____ Domestic International (Country: _____)

Complications during pregnancy? _____ Full-term Premature

Complications during birth? _____

Child's weight at birth? _____ lbs. _____ oz. Child's health at birth? _____

Length of Hospital Stay? _____ Postpartum depression? Yes No

HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio			
Immunizations and dates:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox	
	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	

Was your infant Calm Fussy Colicky Easily comforted Hard to comfort?

Describe: _____

Did your child have any difficulties with Feeding Sleeping Bonding Other?

Describe: _____

Does your child have any health issues? Yes No

Describe: _____

Does your child take any medication? Yes No

Give name/dose/frequency _____

Has your child ever had a Serious accident/illness or Hospitalization? Yes No

Hospitalizations	
Reason	Date/Hospital
Other Serious Accidents/Illnesses	
Reason	Date/Location

Did/does your child have Recurrent ear infections? Have tubes in his/her ears? Yes No

Describe: _____

Did/ does your child have Allergies? Yes No

Describe: _____

Does/did your child have asthma? Yes No

Describe Treatment? _____

Has your child had a Hearing Screening Vision Screening Speech/Language Screening? Yes No

Outcome/Date(s): _____

DEVELOPMENTAL MILESTONES

As accurately as you can remember, how old was your child when s/he: Rolled Over _____ Sat up _____

Creeped _____ Cruised _____ Crawled _____ Walked _____ Talked (2 words) _____ Weaned (bottle/breast) _____

Fed self (spoon) _____ Drank from a cup _____ Toilet trained: Started _____ Completed _____

Does/did your child dislike any of the following position(s)? Yes No

Lying on stomach Describe: _____

Lying on back Describe: _____

How long did your child spend crawling as main form of mobility? _____

Was/Is your child fed? g-tube bottle breast fed? How long? _____

Does your child use a pacifier suck thumb use a bottle? How often? _____

How would you describe your child's feeding/diet?

Normal Picky Eater Restricted Diet Poor Nutrition Unsafe Limited Other

Describe (list preferred foods, concerns): _____

Do you have concerns about your child's development in *any* of these areas?

Speech or Language Motor Skills Social Skills Cognitive (Intellectual) Sensory Behavioral Emotional

Describe: _____

Does your child have any developmental delays or special needs? Yes No

Describe: _____

Has your child had a developmental or diagnostic assessment? Yes No

List (name of facility, date, results): _____

Does your child receive any special services (*i.e.*: Speech, O.T., Behavior Therapy, etc.)? Yes No

Describe: _____

CHILD'S DAILY ROUTINE

What is the best time of day for you with your child? _____

Eating

Does your child feed him/herself? Yes No

Describe: _____

List typical eating/feeding times: _____

Diapering/Toileting

Is your child toilet trained? Yes No "In progress"

Describe Concerns: _____

Dressing/Hygiene/Grooming

Does your child get dressed by themselves? Yes No "In progress"

Describe Concerns: _____

Does your child have difficulties with tooth brushing, hand washing, washing hair, bathing, showering? Yes No "In progress"

Describe Concerns: _____

Does your child have difficulties with hair brushing, haircuts, or nails trimmed ? Yes No "In progress"

Describe Concerns: _____

Sleeping

Describe your child's sleeping arrangement: _____

Does your child go to sleep easily with difficulty with a bottle with a parent have a bedtime ritual?

Describe: _____

Does your child have a regular bedtime? Yes No Wakes at: _____ Naps at: _____ Goes to bed at: _____

Activities and Play

What are your child's favorite activities at home? _____

Where does your child usually play? _____

Does your child *avoid* any physical activities? Yes No

Describe: _____

Does your child attend any other regular groups or classes? Yes No

Describe: _____

Does your child demand a lot of adult attention? Yes No

Describe: _____

Social Relationships

Who are the most important people in your child's life? _____

Does your child usually play alone w/siblings w/peers w/ younger children w/older children w/adults?

When are your child's opportunities to play with other children? _____

Does your child have a hard time making friends? Yes No

Describe: _____

What adult does your child spend the most time with? _____

Day Care/Preschool

Is your child currently in childcare?

When/Where? _____

Is your child currently enrolled in school?

When/Where? _____

Does your child have an Individualized Education Plan (IEP)? Yes No

Do you have concerns regarding school performance? Yes No

Describe: _____

CHILD'S TEMPERMENT & PERSONALITY

How does your child handle separation/transitions? _____

What works best? _____

Is your child attached to any special objects? _____

Does your child have any fears? _____

How does your child express these fears? _____

What helps? _____

When does your child get upset/angry? _____

How does s/he express anger? _____

How do you respond? _____

Describe your child's typical temperament?

Energy

Sedentary Active Very active

Describe: _____

First Reaction (to new people, activities, ideas)

Avoidant Shy Outgoing

Describe: _____

Mood (general emotional tone)

anxious timid curious serious happy other: _____

Describe: _____

Intensity (strength of emotional reactions)

withdraw mild reactions Strong reactions

Describe: _____

Persistence (ease of stopping when involved in an activity)

hard easily redirected hard to focus on an activity

Describe: _____

Sensitivity (to noises, emotions, tastes, textures, stress)

not sensitive mild Very sensitive

Describe: _____

Perceptiveness (notices people, noises, objects)

hardly ever notices turns to looks/notices overly perceptive

Describe: _____

Adaptability (copes with transitions, changes in routine)

slow flexible quickly

Describe: _____

Attention Span/Distractibility

easily distracted sometimes distracted stays focused

Describe: _____

Additional Comments: _____

PARENT COMMENTS

How would you describe parenting your child? _____

What do you find the most challenging or stressful in parenting your child? _____

What kind of discipline do you use and what works best with your child? _____

What has been most joyful for you in parenting your child? _____

What are your goals for your child? _____

Is there anything else you would like us to know about your child? _____

Thank you for taking the time to complete this form..

Parent Signature _____ **Date** _____