Child Development History Questionnaire

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

Child's Name: ☐ M ☐ F		**DOB:**
Previous or referring doctor:	**Date of Last Developmental Exam:**	
Medical Diagnosis:		
Age of Awareness: *(When did you first know about the above diagnosis?)*		

What concerns do you have regarding the child's development in *any* of these areas?

☐ Speech or Language	☐ Fine Motor Coordination	☐ Sensory Processing	☐ Self-Cares
☐ Social Skills	☐ Gross Motor Coordination	☐ Behavioral	☐ Attention
☐ Cognitive/Intellectual	☐ Handwriting	☐ Emotional	☐ Transitions

Describe:

_____
_____
_____
_____

Does the child currently receive any other services for the above areas of concern (i.e. Speech, OT, PT, Behavior Therapy, Family Therapy, Mental Health) ☐ Yes ☐ No

Describe:

_____
_____

If yes, please bring a copy of evaluation(s) with you to first appointment.

Family Structure

Mother's/Guardian's Name_____ Age_____
☐ Living with child ☐ Not living with child

Father's/Guardian's Name_____ Age_____
☐ Living with child ☐ Not living with child

Parents/Guardian(s) are ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
☐ Co-Parenting ☐ Other _____

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

Other members in the household:

Name	Age	Relationship

Health History

Pregnancy and Birth

☐ Vaginal Birth → ☐Full-term ☐ Premature (_____lbs. _____oz.)

☐ Cesarean Birth → ☐Full-term ☐ Premature (_____lbs. _____oz.)

☐ Adopted → ☐ Domestic ☐International _____ Age

Complications during birth ☐ Yes ☐ No (If yes, please explain):
_____

Child's Health History

Immunizations and Dates			
☐ Tetanus		☐ Pneumonia	
☐ Hepatitis		☐ Chickenpox	
☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	
☐ COVID-19		☐ Other	

Hospitalizations ☐ Yes ☐ No (If yes, please describe below):	
Reason	Date/Hospital

Other Serious Accidents/Illnesses ☐ Yes ☐ No (If yes, please describe below):	
Reason	Date/Location

Medications ☐ Yes ☐ No (If yes, please describe below):		
Name	Dose	Frequency

Health Screenings ☐ Yes ☐ No (If yes, please describe below):		
	Outcome	Date
Hearing		
Vision		
Diagnostic Assessments		

Allergies ☐Yes ☐ No (If yes, see below)

List allergies: _____

Treatment Protocol: _____

Asthma ☐Yes ☐ No (If yes, see below)

Treatment Protocol: _____

History of recurrent Ear Infections ☐Yes ☐ No (If yes, see below)

At what age: _____

Treatment Protocol: _____

History of Seizures ☐Yes ☐ No (If yes, see below)

Triggers: _____

Treatment Protocol: _____

Developmental History

Infant Temperament ☐Calm ☐Fussy ☐Colicky ☐Easily Comforted ☐Hard to Comfort

How old was the child when:

Rolled Over		Weaned from bottle/breast		Smiled	
Sat Up		Drank from a cup		Babbled (mamama)	
Creeped		Fed Self with spoon		First Word	
Crawled		Toilet Trained (day)		Pointing	
Walked		Toilet Trained (night)		2+ Word Sentences	

As an infant, did the child dislike any of following positions:

☐Lying on stomach ☐Lying on back ☐Sitting Upright ☐Other: _____

As an infant, was the child fed via

☐G-tube ☐Bottle ☐Breast ☐Other: _____

As an infant, did the child use one or more of the following:

☐Pacifier ☐Suck their thumb ☐Bottle ☐Other: _____

If yes, until what age: _____

Child's Daily Routine

Activities of Daily Living

Does the child struggle with constipation or fecal/urine leaks? ☐Yes ☐No
(If yes please describe) _____

Does the child get dressed independently? ☐Yes ☐No ☐In progress

Does the child have any difficulty with the following tasks:

Tooth brushing	☐Yes ☐No	Hand washing	☐Yes ☐No
Hair washing	☐Yes ☐No	Hair brushing	☐Yes ☐No
Bathing/showering	☐Yes ☐No	Hair cuts	☐Yes ☐No
Nail trimming	☐Yes ☐No	Nose Care	☐Yes ☐No

Does the child go to sleep ☐Easily ☐With Difficulty ☐With an item ☐With a parent

Please describe the child's bedtime routine and sleeping arrangement below:
_____

Education

Is the child currently enrolled in school/daycare: ☐Yes ☐No
If yes, please list name of school/care center and grade (if applicable):
_____

Does the child have an Individualized Education Plan (IEP) or an Individual Family Service Plan (IFSP) ☐Yes ☐No
If yes, please list diagnosis and services received below:
_____

If yes, please bring a copy of evaluation(s) with you to first appointment.

Do you have any concerns regarding school performance? ☐Yes ☐No
If yes, please describe: _____

Play Skills

Please describe the child's favorite toys/games/equipment:_____

Please describe any toys/games/equipment that the child avoids: _____

Does the child attend any extracurricular groups, classes, or clubs? ☐Yes ☐No
If yes, please list: _____

Social Participation

Please list the most important people in the child's life:

Name	Relationship

Does the child usually play:
☐Alone ☐With siblings ☐With peers ☐With younger children ☐With older children ☐With adults

Describe how the child makes friends or engages with peers:
_____

Please describe the child's experience with dogs:
_____
(Therapy Junction provides Animal Assisted Therapy if desired.)

Feeding/Eating

Does the child feed themselves? ☐Yes ☐No

Variety of foods eaten:
☐Very concerned ☐Somewhat concerned ☐Not concerned

Amount of foods eaten:
☐Very concerned ☐Somewhat concerned ☐Not concerned

Please describe preferred foods: _____

Please describe any concerns: _____

Please list typical eating/feeding times: _____

Child's Temperament

Please describe the child's typical temperament:

Child's activity level during the day:
☐Sedentary ☐Active ☐Very Active ☐Other: _____

Child's general emotional tone (mood):
☐Anxious ☐Timid ☐ Curious ☐Serious ☐ Happy ☐Other: _____

Child's first reaction to new people, places, activities, ideas, things, etc.
☐Avoidant ☐Shy ☐Outgoing ☐Calm ☐ Other: _____

Child's emotional reactions when upset:
☐Withdrawn ☐Mild ☐Strong ☐Other: _____

Child's response to transitions, changes in routine, etc.
☐Difficult ☐Somewhat Difficult ☐Flexible

Child's attention to a task/activity:
☐Easily distracted ☐Sometimes distracted ☐Focused ☐Other _____

How does the child express anger? _____

How does the child express joy? _____

How does the child handle separation from their caregiver?
☐Easily ☐Sometimes difficult ☐Difficult
What has worked in the past? _____

Is the child attached to any special objects? ☐ Yes ☐ No
If yes, please list: _____

Parent Comments

What have been joyful experiences with the child?

_____

_____

What have been challenging experiences with the child?

_____

_____

Parent Comments Continued

What kind of discipline/rewards do you use with the child?

_____

_____

What are the goals you have for the child?

_____

_____

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

_____

_____

Thank you for taking the time to complete this form. We look forward to working with you.

Parent Signature: _____ Date: _____