DEVELOPMENTAL HISTORY QUESTIONNAIRE

Client Name: _____ **Client ID**: _____ **Date**: _____ **Setting**: *office*

Due to the age of your child it is very important that we get the most comprehensive information to provide the best level of care. Please answer the questions to the best of your ability. Your child's therapist will review to ensure its completeness and clarify any information as necessary.

PRENATAL HISTORY

How was your (child's mother's) health during pregnancy?
☐ Good ____ ☐ Fair _____ ☐ Poor _____ ☐ Don't know

Did you (or his/her mother) have any illness or complications during pregnancy with this child? What type? _____

_____

How old were you (or child's mother) when s/he was born? _____

Do you recall any of the following substances or medications being used during pregnancy?
Beer or wine ____ How many times? _____
Coffee or other caffeine (Cokes, etc.) _____ How many times? _____
Hard liquor? _____ How many times? _____
Cigarettes? _____ How many times? _____

Did mother ingest any of the following substances? ☐No ☐Yes (if yes which ones)
____ Valium (Librium, Xanax)
____ Tranquilizers
____ Anti-seizure medications (e.g., Dilantin)
____ Antibiotics (for viral infections)
____ Sleeping pills
____ Other (please specify) _____

Was there toxemia or eclampsia? ☐No ☐Yes ☐ Don't Know

Was there an Rh factor incompatibility? ☐No ☐Yes ☐ Don't Know

Was the pregnancy planned or unplanned? Wanted or unwanted? (circle one)

Was there anything unusual about the delivery or birth? _____

Was s/he born on schedule? If not how early or late?
Early _____ How many weeks total _____
Full Term 9 mos. ____
Late _____

What was the duration of labor?_____

Were you given any drugs to ease the pain during labor? ☐No ☐Yes ☐Don't Know
If yes what was the name of the medication: _____

Were there any signs of fetal distress during labor or birth? ☐No ☐Yes ☐Don't Know

Was the delivery:
Normal? ☐No ☐Yes
Breech? ☐No ☐Yes
Caesarian? ☐No ☐Yes
Forceps? ☐No ☐Yes
Induced? ☐No ☐Yes

What was the child's birth weight?_____

Were there any health complications following birth? ☐No ☐Yes If yes, please describe: _____

_____

POSTNATAL PERIOD AND INFANCY

Were there early infancy feeding problems? ☐No ☐Yes

Was the child colicky? ☐No ☐Yes

Were there early infancy sleep pattern difficulties? ☐No ☐Yes If yes, what type? _____

Were there problems with the infant's alertness? ☐No ☐Yes If yes, please describe. _____

Did the child experience any health problems during infancy? ☐No ☐Yes If yes, please describe. _____

Did the child have any congenital problems? ☐No ☐Yes If yes, please describe. _____

Was the child an easy baby? By that I mean did s/he cry a lot? Did s/he follow a schedule fairly well?
☐ Very easy ☐ Easy ☐ Average ☐ Difficult ☐ Very Difficult

How did the baby behave with other people?
☐ More sociable than average ☐ Average sociability ☐ Less sociable than average

When s/he wanted something, how insistent was s/he?
☐ Very insistent ☐ Pretty insistent ☐ Average ☐ Not very insistent ☐ Not at all insistent

How would you rate the activity level of the child as an infant / toddler?
☐ Very active ☐ Active ☐ Average ☐ Less active ☐ Not active

DEVELOPMENTAL MILESTONES

At what age did s/he sit up? ☐ 3-6 mos. ☐ 7-9 mos. ☐ Don't know

At what age did s/he crawl? ☐ 6-12 mos. ☐ 13-18 mos. ☐ Over 18 mos. ☐ Don't know

At what age did s/he walk? ☐ Under 1 yr ☐ 1-2 yr ☐ 2-3 yr ☐ Don't know

At what age did s/he speak single words (other than mama or dada)? _____

At what age did s/he string two or more words together? _____

At what age was s/he toilet trained (bladder control)? _____

At what age was s/he toilet trained (bowel control)? _____

Approximately how much time did toilet training take from onset to completion? _____

CURRENT HEALTH STATUS:

How would you describe his/her health?
☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

How is his/her hearing?
☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

How is his/her vision?
☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor
How is his/her gross motor coordination (large muscle development – walking, running, jumping)?
☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

How is his/her fine motor coordination (small muscle development – finger/hand)?
☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

How is his/her speech articulation (speech and language development)?
☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Has s/he had any chronic health problems (e.g., asthma, diabetes, heart condition)?
☐No ☐Yes If yes, please specify: _____

When was the onset of any chronic illness? _____

Which of the following illnesses has the child had?
☐ Mumps ☐ Chicken Pox ☐ Measles ☐ Whooping Cough ☐ Scarlet Fever ☐ Pneumonia ☐ Encephalitis
☐ Otitis Media ☐ Lead Poisoning ☐ Seizures
Other diseases (specify) _____

Has s/he had any accidents resulting in the following? Please give date and cause of injury.
☐ Broken Bones ☐ Severe Lacerations ☐ Head Injury ☐ Severe Bruises ☐ Stomach Pumped
☐ Eye Injured ☐ Lost Teeth ☐ Sutures
Other (specify) _____
Were any of these injuries traumatic for the child? ☐No ☐Yes If yes, please describe. _____
_____

Has s/he been diagnosed with any or had surgery for of the following illnesses:
☐ Tonsillitis ☐ Adenoids ☐ Hernia ☐ Appendicitis ☐ Eye, ear, nose & throat ☐ Digestive disorder ☐ Urinary Tract____
☐ Leg or arm ☐ Burns
Other____
Were any of the illnesses or surgeries traumatic for the child? ☐No ☐Yes If yes, please describe. _____
_____

Is there any suspicion of alcohol or drug use? ☐No ☐Yes If yes, please describe. _____

Is there any history of physical/sexual abuse? ☐No ☐Yes If yes, please describe. _____
_____

Does s/he have any problems sleeping?
☐ None ☐Difficulty falling asleep ☐Sleep continuity disturbance ☐Early morning awakening

Is s/he a restless sleeper? ☐No ☐Yes

Does s/he have bladder control problems at night? ☐No ☐Yes
If yes, how often? _____
If yes, was s/he ever continent? ☐No ☐Yes If yes, does it even occur during the day? ☐No ☐Yes

Does s/he have bowel control problems at night? ☐No ☐Yes
If yes, how often? _____
If yes, was s/he ever continent? ☐No ☐Yes If yes, does it even occur during the day? ☐No ☐Yes

Does s/he have any appetite control problems? ☐No ☐Yes If yes does s/he
☐ Overeats ☐ Average ☐ Under eats

Please indicate if prescribed any of the following:

Ritalin ☐No ☐Yes If yes, duration of use_____
Concerta ☐No ☐Yes If yes, duration of use_____
Adderall ☐No ☐Yes If yes, duration of use_____
Strattera ☐No ☐Yes If yes, duration of use_____
Dexedrine ☐No ☐Yes If yes, duration of use_____
Cylert ☐No ☐Yes If yes, duration of use_____
Mood Stabilizer ☐No ☐Yes If yes, duration of use_____ Name: _____
Antidepressant ☐No ☐Yes If yes, duration of use_____ Name: _____
Antianxiety ☐No ☐Yes If yes, duration of use_____ Name: _____
Tranquilizers ☐No ☐Yes If yes, duration of use_____ Name: _____
Anticonvulsants ☐No ☐Yes If yes, duration of use_____ Name: _____
Other prescription drugs:
Type_____ Duration of use _____
Type_____ Duration of use _____

Has s/he ever had any of the following forms of psychological treatment? If so, please elaborate:

Individual psychotherapy ☐No ☐Yes Duration of therapy_____
Group psychotherapy ☐No ☐Yes Duration of therapy_____
Family therapy with child ☐No ☐Yes Duration of therapy_____
Inpatient evaluation ☐No ☐Yes Type of evaluation: _____
Residential treatment ☐No ☐Yes Duration of placement: _____

Is there any self-care, feeding, dressing or grooming concerns? _____
_____

PREVIOUS ATTEMPTS TO IMPROVE BEHAVIOR/OUTCOME:

What strategies have been implemented to address these problems or goals. (Check which have been successful)
☐ Verbal reprimands ☐ Time out (isolation) ☐ Removal or privileges ☐ Rewards ☐ Physical punishment
☐ Submission to child ☐Avoidance of child
☐Other_____

On the average, what percentage of the time does s/he comply with initial commands?
☐1-20% ☐20-40% ☐40-60% ☐60-80% ☐80-100%

On the average, what percentage of the time does s/he eventually comply with initial commands?
☐1-20% ☐20-40% ☐40-60% ☐60-80% ☐80-100%

To what extent are you and your spouse consistent with respect to disciplinary strategies?
☐ Most of the time ☐Some of the time ☐None of the time

Have any of the following stress events occurred within the past 12 months?
☐Parents divorced or separated ☐Family accident or illness ☐Death in family ☐Parent changed job
☐Changed schools ☐Family moved ☐Family financial problems ☐Other (please specify) _____

SOCIAL HISTORY

How does s/he get along with his/her brothers/sisters?
☐ Doesn't have any ☐ Better than average ☐ Average ☐ Worse than average

How does s/he get along with peers?
☐ Easier than average ☐ Average ☐ Worse than average ☐ Don't know

On average, how long does s/he keep friendships?
☐ Less than 6 months ☐ 6 months - 1 year ☐ More than 1 year ☐ Don't know

SYMPTOMS & BEHAVIORS OBSERVED:

Which of the following are considered to be a significant problem at the present time?

(Please make an entry for every item with 0 = No; 1 = Yes)

Fidgets____
Difficulty remaining seated____
Easily distracted____
Difficulty waiting turn____
Often blurts out answers to questions before they are completed____
Difficulty following instructions____
Difficulty sustaining attention____
Shifts from one activity to another____
Difficulty playing quietly____
Often talks excessively____
Often interrupts or intrudes on others____
Often does not listen____
Often loses things____
Work and materials are frequently disorganized compared to others the same age ____
Does not anticipate consequences of failure to complete tasks ____
Has difficulty initiating tasks ____
Has difficulty completing tasks ____
Has difficulty inhibiting inappropriate behaviors or actions ____
Frequently impulsive or acts before thinking ____
Often engages in physically dangerous activities ____
When did these problems begin? (specify age)_____

Which of the following are considered to be a significant problem at the present time?

(0 = No; 1 = Yes)
Often loses temper____
Often argues with adults____
Often actively defies or refuses adult requests or rules. ____
Often deliberately does things that annoy other people____
Often blames others for own mistakes____
Often touchy or is easily annoyed by others____
Often angry or resentful____
Often spiteful or vindictive____
Often swears or uses obscene language____
When did these problems begin? (specify age) _____

Which of the following are considered to be a significant problem at the present time?

(0 = No; 1 = Yes)
Stolen without confrontation____
Run away from home overnight at least twice____
Lies often____
Deliberate fire setting____
Often truant____
Breaking and entering____
Destroyed others' property____
Cruel to animals____
Forced someone else into sexual activity____
Used a weapon in a fight____
Often initiates physical fights____
Stolen with confrontation____
Physically cruel to people____
When did these problems begin? (specify age) _____

Which of the following are considered to be a significant problem at the present time?
(Please make an entry for each item with 0 = No; 1 = Yes)
Unrealistic and persistent worry about possible harm to attachment figures____
Unrealistic and persistent worry that a calamitous event will separate her/him from attachment figures. ____
Persistent school refusal____
Persistent refusal to sleep alone____
Repeated nightmares regarding separation from caregivers ____
Somatic complaints or often not feeling well ____
Excessive distress in anticipation of separation from attachment figure____
Excessive distress when separated from home or attachment figures____
Unrealistic worry about future events____
Unrealistic worry about appropriateness of past behavior____
Unrealistic concern about competence____
Marked self-consciousness____
Excessive need for reassurance____
Marked inability to relax____
When did these problems begin? (Specify age) _____

Which of the following are considered to be a significant problem at the present time?
(0 = No; 1 = Yes)
Depressed or irritable mood most of day, nearly every day____
Diminished pleasure in activities____
Decrease or increase in appetite assoc. with possible failure to make weight gain____
Difficulty initiating sleep at bedtime taking more than 30 minutes typically ____
Difficulty waking in the morning, i.e., feeling groggy or drowsy for more than five minutes after getting up ____
Insomnia or inability to maintain adequate sleep during the night ____
Hypersomnia or sleeping too much or more than typically expected ____
Psychomotor agitation or retardation____
Low energy, fatigue or loss of energy at times ____
Feeling of worthlessness or excessive inappropriate guilt____
Makes statements of not feeling good about life or not wanting to be alive at times ____
Suicidal ideation indicating thoughts about taking ones own life _____
Suicidal attempt in the past (indicate date(s) or age(s) ____
Threatens others ____
Poor appetite or overeating____
Low self-esteem____
Poor concentration or difficulty making decisions____
Feelings of hopelessness____
Never without symptom for 2 mos. over a 1 yr period____
When did these problems begin? (specify age) _____

Which of the following symptoms have been exhibited in the past or present?
(Please make an entry for each item with 0 = No; 1 = Yes)
Stereotyped mannerisms____
Odd posture____
Excessive reaction to noise or fails to react to loud noise____
Overreacts to touch____
Compulsive rituals____
Obsessive verbal themes _____
Motor tics____ Vocals Tics____ Tourette's Disorder _____
Loose thinking e.g. tangential ideas, circumstantial speech____
Odd fascinations _____
Strange ideas _____
Going from one idea to another without reason _____
Many ideas at once _____
Delusions _____
Paranoia or fear or suspicion of being watched or hurt that is not realistic _____
Hallucinations____ Visual? _____ Auditory?_____

Inflated sense of self in speech _____
Inflated sense of self in behavior and actions _____
Refuses to accept adult authority _____
Refuses or inability to take responsibility for behavior _____
Frequent or unusually severe “melt downs” _____
Difficulty remembering own behaviors _____
Disoriented, confused, staring, or "spacey"____
Incoherent speech (mumbles, jargon, repetitive phrases or words) ____
Excessive mood changes no matter what the situation is or where you are____
Explosive temper with minimal provocation____
Excessive clinging, attachment, or dependence on adults____
Unusual fears____
Strange aversions____
Which of the following symptoms have been exhibited in the past or present?
Panic attacks____
Excessively restrictive or bland affect____
Situationally inappropriate emotions____
Little or no interest in peers____
Significantly indiscreet remarks____
Initiates or terminates interaction inappropriately.____
Qualitatively abnormal social behavior____
High or specialized interest in certain objects or things or topics _____
Excessive reaction to changes in routine_____
Interprets what others say literally _____
Fails to understand subtle intentions of others or jokes _____
Abnormalities of speech____
Self-harm in the past ____
Self-mutilation in the past ____
Self-mutilation currently occurring ____

Please provide any information not addressed above that would help with assessment/treatment and/or help in understanding this child’s/adolescent’s needs.