Developmental Questionnaire

Today's Date_____

Child's Name: _____Birthdate: _____ Age: _____ Sex: ☐Male ☐ Female

Person completing this form: _____ Relationship to Child: _____

Child's Primary Care Physician: ____ _____Referred by: _____

STATEMENT OF THE PROBLEM

Describe as completely as possible the reason for referral / concern: _____

_____

When was the problem first noticed? _____

What do you feel are some reasons for this problem? _____

Has your child received help for this problem? If so, what type? _____

Where? _____ When? _____

What would you like to accomplish through this assessment process? _____

What grade is your child in at school? _____ Who is your child's teacher? _____

☑	Has the child ever been diagnosed with:	BY WHOM	WHEN	DO YOU AGREE? Yes	No
	Autism				
	Cerebral Palsy				
	Developmental Syndrome				
	Fine Motor Problem				
	Gross Motor Problem				
	Head Injury				
	Hearing Loss				
	Learning Problem				
	Intellectual Disability				
	Neurological Problem				
	Speech and or Language Problem				
	Visual Impairment				
	Other (specify)				

Mark any evaluations or therapy received. If received by the child, mark a "C"; if received by another family member, mark an "F".

_____Speech-Language _____Occupational _____Behavioral _____Psychological

_____Physical _____Hearing _____Counseling _____Nutritional

_____Parent Training _____Educational _____Developmental

Describe results: _____

PREGNANCY AND BIRTH HISTORY

Were there any complications, illnesses, accidents, or stress-producing events during pregnancy? ☐Yes ☐No

If yes, please explain: _____

Was the baby born prematurely? ☐Yes ☐No How many weeks early? _____

Where was the baby born? _____How long was the infant in the hospital? (days/months)_____

Birth Weight: _____APGAR Scores: _____

Were there any unusual problems at birth? ☐Breathing difficulty ☐Feeding difficulties

Explain: _____

MEDICAL HISTORY

Is the child now under the care of a doctor(s)? ☐Yes ☐No Who? _____ Why? _____

Are immunizations up-to-date? ☐Yes ☐No

Is the child in pain? ☐Yes ☐No If yes, please explain: _____

Is the child taking medication? ☐Yes ☐No Type(s)? _____ Why? _____

Is the child taking herbs? ☐Yes ☐No Type(s)? _____ Why? _____

Do you think hearing is normal? ☐Yes ☐No

Has child's hearing ever been tested? ☐Yes ☐No If so, when? _____

Where? _____ Results? _____

Do you think your child's vision is normal? ☐Yes ☐No Does your child wear glasses? ☐Yes ☐No

Has child's vision ever been tested? ☐Yes ☐No If so, when? _____

Where? _____ Results? _____

Has your child experienced any of the following?

	AGE	EXPLAIN		AGE	EXPLAIN
Adenoidectomy			Eye Problems		
Allergies			Heart Problems		
Asthma			High Fevers		
Blood Disease			Meningitis		
Chronic Colds			Muscle Disorder		
Dental Problems			Nerve Disorder		
Diabetes			Seizures		
Ear Infections			Tonsillectomy		
Encephalitis			Other		

DEVELOPMENTAL HISTORY

At what age did the following occur?

Held head up:	Rolled over:	Sat alone unsupported:	Crawled:	Stand alone:	Walked alone:
Weaned from bottle:	Said first words:	Put words together:	Was toilet trained:	Followed simple directions:	

Family History

Parents' ages at birth of child: Father_____ Mother _____ Highest grade level attended: Father_____ Mother _____

Father occupation: _____ Mother occupation: _____

Please list siblings:

NAME	SEX	DATE OF BIRTH

Have any relatives (including parents, grandparents, siblings, aunts, uncles, cousins) had any of the following?

	YES	NO	IF YES, WHO?
Autism			
Developmental problem			
Drug or alcohol problems			
Hearing problems			
Hyperactivity			
Learning problems			
Mental retardation			
Psychological problems			
Seizures or epilepsy			
Severe behavior problems			
Speech problems			

Have there been any recent significant stress-producing events? ☐ Yes ☐ No For whom? ☐ Parent ☐ Child

If yes explain: _____

_____

_____

Feeding:

Check these as they applied / apply to your child:

	Yes	No	Explain (give age)
Difficulty sucking			
Difficulty chewing			
Difficulty swallowing			
Picky eater			
Prefers soft foods			
Excessive drooling			
Food comes out nose			

Language/ Communication:

What is the primary language spoken in the home: _____

What other language is the child exposed to: _____ Where: _____ How often: _____

How does your child communicate his/her needs: _____

_____

How much of the child's speech do you understand? ☐0% ☐10% ☐25% ☐50% ☐75% ☐100% ☐Too young to talk

Does your child respond when you call his/her name? ☐Yes ☐No

Is your child able to follow simple direction such as come here, sit down, stop? ☐Yes ☐No

Is your child able to follow multiple step directions? ☐Yes ☐No

Does your child use words/phrases to:

Make Requests: ☐ Yes ☐ No

Comment: ☐ Yes ☐ No

Protest: ☐ Yes ☐ No

Answer questions: ☐ Yes ☐ No

Ask questions: ☐ Yes ☐ No

Play/Behavior:

Please answer yes/no about the following behaviors:

	Yes	No	Explain:
Is your child able to separate from parent/caregivers:			
Notice when you leave the room/house:			
Easy to discipline:			
Make eye contact with others:			
Play social games (peek-a-boo paddy cake):			
Show interest in other children:			
Initiate interaction with other children:			
Play with objects and/or toys appropriately:			

	Yes	No	Explain:
Play with other children appropriately:			
Imitate actions in play of other children or adults:			
Is your child able to share toys with other children or adults:			
Is your child able to take turns in activities/games:			
Know when you are upset with him/her:			

What are your child's favorite toys/ activities? _____

Does your child exhibit any of the following behaviors?

☐ Aggressiveness ☐ Lives in own world

☐ Biting ☐ Hitting

☐ Injures self ☐ Tantrums

☐ Repetitive Behaviors ☐ Rocking

Describe any other behavior that is a problem to the parents: _____

_____

How do you manage the behavior(s)? _____

_____

Sensory Processing:

Please answer the following statements:

	Almost Always	Occ.	Rarely	N/A
Does your child have irregular sleep patterns?				
Does your child seem generally weak/ floppy when held?				
Does your child seem clumsy or uncoordinated?				
Does the feel of certain clothing irritate your child? (Shirt, pants, socks, shoes)				
Does your child resist being held?				
Does your child avoid messy play activities such as finger painting, sand, glue etc.?				
Does your child seem excessively fearful of movement? (e.g. going up or down stairs, swings, slides, other playground activities)				
Does your child seek out all kinds of movements that interfere with his/her daily routines?				
Does your child startle or become distressed by loud or unexpected sounds?				
Is your child bothered by and have a difficulty concentrating with loud background noise such as construction work or machinery?				
Does your child appear not to hear certain sounds?				
Is your child sensitive to or bothered by light (squint, cries, closes eyes etc.)?				