

YOUR CHILD'S DEVELOPMENTAL QUESTIONNAIRE
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This questionnaire will help me evaluate your child. Please answer as fully as possible.

Child's name: _____ Birth date/Age: _____

Parents' names: _____

Form filled out by: _____ Date: _____

Child's school _____ Grade _____

Who referred you for this evaluation? _____

Father's name _____ Age _____

Father's school level completed _____ Employment _____

Ethnic background (optional) _____

Mother's name _____ Age _____

Mother's school level completed _____ Employment _____

Ethnic background (optional) _____

Marital status of parents _____

Length of marriage _____ Date of divorce/separation _____

With whom does the child live? _____

INFANCY

Were there any complications with your pregnancy and/or with the birth of your child?
(If adopted, please note)

Describe your child's temperament as a baby.

Were there any feeding, sleeping or other problems as a baby? If so, what were they?

TODDLERHOOD

Did you have any concerns about your child as a toddler (i.e. temper tantrums, toilet training, separation)?

Did any significant events occur during the first three years of the child's life (move, birth of sibling, death in family, absence of spouse, job change, marital difficulties, etc.)?

NURSERY SCHOOL

Did/does your child separate easily when you took him or her to nursery school? _____

Did/does your child like nursery school? _____

How did/does your child relate with the other children? _____

What did/does the teacher say about his/her behavior and development?

At the end of nursery school, was there any question about his/her readiness for kindergarten? If so, why? _____

ELEMENTARY SCHOOL

Do you or any of your child's teachers have concerns about your child at school?

How does your child get along with other children?

What do the child's teacher(s) say about your child's behavior and development?

Please list the schools your child has attended:

- K _____
- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____

Describe any learning problems your child has had.

Describe the child's relationship with other students.

Has your child had any medical problems/major illnesses/accidents?

How do you discipline your child?

What sex information does the child have (if age appropriate for your child)?

Who gave it? _____

FAMILY HISTORY

Part of our evaluation of a child or adolescent involves reviewing the family history of psychiatric and neurological conditions. Please indicate if there is a family history of the following:

| | Yes or No | Family Member(s) |
|-------------------------------|------------------|-------------------------|
| Depression | | |
| Suicide | | |
| Anxiety | | |
| Phobias | | |
| Panic Attacks | | |
| Shyness | | |
| Social Difficulties | | |
| Obsessive Compulsive Disorder | | |
| Tourette's Syndrome | | |
| Tics | | |

| | | |
|------------------------------------|--|--|
| Seizure Disorders | | |
| Eating Disorders | | |
| Temper Problems | | |
| Drug Addiction | | |
| Alcoholism | | |
| Learning Problems | | |
| ADHD | | |
| Behavior Problems | | |
| Trouble with the Law | | |
| Autism | | |
| Schizophrenia | | |
| Bipolar Illness (Manic Depression) | | |
| Psychiatric Hospitalization | | |
| Mental Health Treatment | | |
| Psychiatric Medication Use | | |

PREVIOUS CONTACT WITH MENTAL HEALTH PROFESSIONALS

Part of the initial evaluation is reviewing the treatment history. Please list below any previous contacts with mental health professionals, including psychiatrists, psychiatric nurses, social workers, psychologists, etc. Please also list any mental health related contacts with physicians (i.e. pediatrician may be prescribing medication for mental health concerns). I will not contact any of these providers without your written permission. If there have been no previous contacts with mental health professionals, please sign and date here: _____

If previous contacts have occurred, please provide the following information:

1. Dates of contact _____
 Name: _____
 Address: _____
 Telephone: _____

2. Dates of contact _____
 Name: _____
 Address: _____
 Telephone: _____

3. Dates of contact _____
 Name: _____
 Address: _____
 Telephone: _____