

**YOUR TEEN'S DEVELOPMENTAL QUESTIONNAIRE**  
**Ann Turner, PhD, LCSW-C, CEAP**

This information will help me evaluate your teenager. 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?  
\_\_\_\_\_

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**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 or sleeping problems? If so, what were they?  
\_\_\_\_\_

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**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 your child's life (move, birth of sibling, death in family, absence of spouse, job change, marital difficulties, etc.)?  
\_\_\_\_\_  
\_\_\_\_\_

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**NURSERY SCHOOL**

Did your child separate easily when you took him or her to nursery school? \_\_\_\_\_

Did your child like nursery school? \_\_\_\_\_

How did your child relate with the other children? \_\_\_\_\_

What did 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? \_\_\_\_\_

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**ELEMENTARY SCHOOL**

Did you or any of your child's teachers have concerns about your child when they were in elementary school?

How did your child get along with other children?

What did the child's teacher say about the 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 had during these years.

Describe the child's relationship with other students.

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

How do you discipline your child?

What sex information does the child have?

Who gave it? \_\_\_\_\_

**ADOLESCENCE**

Child's primary physician: \_\_\_\_\_

Is child under a doctor's care? \_\_\_\_\_ If so, why? \_\_\_\_\_

Is child currently taking medication? \_\_\_\_\_

If so, what is it and why? \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_ By whom? \_\_\_\_\_

Describe any self destructive behavior demonstrated by your child. (Have you noticed any signs that the child may be hurting him/herself, such as marks on the body?)

Describe any concerns you have about your child's weight or eating habits:

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Does your child ever appear depressed or withdrawn? If so, is it during certain situations?

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How does your child relate to other teenagers?

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How does your child spend their spare time?

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With whom does your child share personal information?

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Has your child ever been pregnant, or responsible for a pregnancy? \_\_\_\_\_

Describe any school behavior problems your child has experienced: \_\_\_\_\_

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Has your child ever received psychological or educational testing? If so, when was it and who administered the test:

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Please list schools your child has attended:

7 \_\_\_\_\_

8 \_\_\_\_\_

9 \_\_\_\_\_

10 \_\_\_\_\_

11 \_\_\_\_\_

12 \_\_\_\_\_

College \_\_\_\_\_

### **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:

	<b>Yes or No</b>	<b>Family Member(s)</b>
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: \_\_\_\_\_

Please list additional contacts below: