9100 White Bluff Road • Suite 601
Savannah, Georgia 31406
SavannahBehavior@gmail.com
P: 912.436.6789 • F: 912.436.6835

# CHILD DEVELOPMENT QUESTIONNAIRE

The purpose of this questionnaire is to obtain information about your child and family, which will help us understand your child more completely. Please feel free to add as much information as you wish, and use the back of these pages if you need more room for your answers. Also, I will be glad to discuss any questions that you would like to talk about in person, rather than answering on this questionnaire. I appreciate the time and effort necessary to complete this questionnaire. Please be reminded that the information you share is confidential and cannot be released without explicit written consent.

## General Information

Child's Name ______________________________ Date: ____________

(first) (middle) (last)

Child's Birthday __________ Age ____ School ________________ Grade ___

Person completing this form (name) ______________________________

Relationship to child ______________ Phone (home) ________(work) __________

Address ______________________________

______________________________

(City) (State) (Zip code) (County)

Who referred your child to Savannah Behavioral Pediatrics? ____________________

For what reason? (describe the problem) ______________________________

______________________________

______________________________

______________________________

When was this problem first noticed? ______________________________

What is your understanding of your child's problem and what would you like addressed in this evaluation?

______________________________

______________________________

______________________________

Are you concerned about autism? YES NO

## Family Information

Your child is currently living with (please check one):

| | | |
|---|---|---|
| __ both parents | __ mother | __ father |
| __ mother and step-father | __ father and step-mother | __ other, please specify: |

| Caregiver 1 (Circle: Biological adoptive other) | Caregiver 2 (Circle: Biological adoptive other) |
|---|---|
| Name ________________________________ | Name ________________________________ |
| Age _____ Highest grade completed __________ | Age _____ Highest grade completed _________ |
| Occupation ___________________________ | Occupation ___________________________ |
| Place of employment ____________________ | Place of employment ____________________ |
| Work phone ___________________________ | Work phone ___________________________ |

Has your child ever experienced any parental separations, divorces, or death(s)? YES NO

If yes, how old was he/she and what were the circumstances? ______________________________

______________________________________________________________________

List child's brothers and sisters (use the back of this sheet if necessary):

| Name | Age | Gender | Living in the home? |
|---|---|---|---|
| | | | Yes No |
| | | | Yes No |
| | | | Yes No |

List other people who are currently living in the home (use the back of this sheet if necessary):

| Name | Age | Gender | Relationship to child |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has the family ever moved? Yes No If yes, how many times, from where to where, and when? _____

______________________________________________________________________

Please note which family member (e.g., father, maternal grandmother, etc.) has had any of the following:

| | |
|---|---|
| ______ Attention-deficit/hyperactivity (ADHD) | ______ Other chronic illness (which one _________ ) |
| ______ Seizure disorder or epilepsy | ______ Speech/language difficulties |
| ______ Other neurological disorder (e.g., stroke) | ______ Drug or alcohol abuse |
| ______ Bipolar Disorder | ______ Learning disability (specify reading, math, etc.) |
| ______ Autism/Aspergers Disorder | ______ Repeated grade(s) in school |
| ______ Thyroid disease | ______ Mental retardation |
| ______ Genetic disorder (which one _________ ) | ______ Depression, anxiety, or other psychiatric illness |
| ______ Schizophrenia | |

## Pregnancy and Birth History

During the pregnancy with your child, did the mother experience any of the following complications?

| | NO | YES | If yes, please describe. |
|---|---|---|---|
| Infection | ___ | ___ | ______________________________ |
| Bleeding | ___ | ___ | ______________________________ |
| Excessive weight gain/loss | ___ | ___ | ______________________________ |
| Unusual physical strain/injury | ___ | ___ | ______________________________ |
| High blood pressure/toxemia | ___ | ___ | ______________________________ |
| Heart problems | ___ | ___ | ______________________________ |
| Gestational diabetes | ___ | ___ | ______________________________ |
| Kidney problems | ___ | ___ | ______________________________ |
| Anemia | ___ | ___ | ______________________________ |
| Unusual emotional strain | ___ | ___ | ______________________________ |
| Drank alcoholic beverages | ___ | ___ | Frequency ______________________ |
| Took medications or drugs | ___ | ___ | Type/Frequency __________________ |
| Smoked cigarettes | ___ | ___ | Frequency ______________________ |
| Other problem or illness | ___ | ___ | ______________________________ |

Estimated length of pregnancy _________ (weeks)    Age of mother when child was born ____________

Was labor induced?  YES  NO    If yes, for what reason? ______________________________

Type of delivery: ___ Vaginal ___ Cesarean ___ Breech    Were forceps used?  YES  NO

Birth weight _______ lbs. _______ oz.  Birth length: ________ in.

Did the baby need medical assistance to start breathing?  YES  NO

Was the baby in the Neonatal Intensive Care Unit or other special care nursery?  YES  NO
If yes, please explain ______________________________________________

Did the baby require any other special treatment at the time of birth?  YES  NO
If yes, please describe ______________________________________________

Check any of the following complications for the baby during the first month of life:

| | | | |
|---|---|---|---|
| ___ Breathing problems | ___ Convulsions (seizures) | ___ Skin rash | ___ Infection |
| ___ Excessive vomiting | ___ Jaundice (yellow) | ___ Birth defect | ___ Injury |
| ___ Excessive crying | ___ Feeding difficulties | ___ Other (describe _______________ ) | |

How long did the baby stay in the hospital after birth? ______________________________

## Health and Medical History

Has your child had any of the following?

| | NO | YES | Age(s) | Please describe |
|---|---|---|---|---|
| Convulsions, seizures, staring spells | ___ | ___ | _____ | ____________________ |
| Other neurological condition | ___ | ___ | _____ | ____________________ |
| Vision or eye problem | ___ | ___ | _____ | ____________________ |
| Ear infection/hearing problem | ___ | ___ | _____ | Ear tubes?__________ |
| Asthma and/or allergies | ___ | ___ | _____ | List allergens__________ |
| Head (brain) injury | ___ | ___ | _____ | ____________________ |
| Other serious injury | ___ | ___ | _____ | ____________________ |
| Lead poisoning or toxic exposure | ___ | ___ | _____ | ____________________ |
| Tics or twitches | ___ | ___ | _____ | ____________________ |
| Other major illness or problem | ___ | ___ | _____ | ____________________ |

Has your child ever been taken to the emergency room, been hospitalized, or had outpatient surgery since birth? YES NO If yes, please describe ______________________________
______________________________________________________________

Has your child had a medical check up within the last 12 months? YES NO
What were the medical findings? ______________________________
Who is your child's family doctor or pediatrician? ______________________________
Date of most recent vision screening ________ Results of exam ____________________
Does your child wear glasses? YES NO If yes, when? ____________________
Date of most recent hearing screening _______ Results of exam ____________________

Please provide the following information about long-term medications your child has taken in the past or is currently taking (that is, medications taken for more than 6 months):

Name of medication | Dosage | Ages when prescribed | Reason for prescription

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Has your child ever had a psychological evaluation or received psychotherapy? YES NO
If yes, at what age, for what reason, and with whom? ______________________________
______________________________________________________________

Has your child ever had a neurological evaluation (e.g., EEG, MRI)? YES NO
If yes, at what age, for what reason, and with whom? ______________________________
______________________________________________________________

## Developmental History

Please indicate the age at which your child first did the following. If you do not remember the exact age, give the approximate age, as best you can remember:

| Gross Motor | Age | Fine Motor | Age | Social/Language | Age |
|---|---|---|---|---|---|
| Sat unsupported | ______ | Fed self with spoon | ______ | Smiled | ______ |
| Crawled | ______ | Scribbled | ______ | Spoke first words | ______ |
| Took first steps | ______ | Tied shoes | ______ | Spoke in phrases | ______ |

At what age was your child potty trained during the day? __________ during the night? ____________

Did wetting occur after toilet training? YES NO If yes, at what age(s) ______________

Did soiling occur after toilet training? YES NO If yes, at what age(s) ______________

If for a medical reason, please describe ________________________________________

Has your child experienced any motor problems, such as clumsiness, difficulty walking, incoordination, etc? YES NO If yes, please describe ________________________________________

________________________________________

Which hand does your child use for writing or drawing? R L For eating? R L Other________? R L

Is there anyone in your child's family who is left-handed? Who?____________________________

Please describe any difficulties with your child's handwriting. ____________________________

Has he/she received occupational or physical therapy? YES NO

If yes, when, where, and for what reason? ________________________________________

________________________________________

Has your child experienced any of the following speech/language problems? If yes, please describe.

| | | | |
|---|---|---|---|
| Says some sounds incorrectly | YES | NO | Which ones?____________________ |
| Stutters or stammers | YES | NO | ____________________ |
| Unusual tone of voice | YES | NO | ____________________ |
| Hard to understand | YES | NO | ____________________ |
| Unable to understand other people's emotions | YES | NO | ____________________ |

Has he/she received speech/language therapy? YES NO

If yes, when, where, and for what reason? ________________________________________

________________________________________

What is your child's bedtime? ______ PM

What time does your child fall asleep? ______ PM

What time does your child wake up ______ AM

Does he/she have sleeping problems? YES NO describe ____________________________

Does your child snore when asleep? YES NO describe ____________________________

Is your child a fussy eater? YES NO Please describe any concerns about your child's eating patterns or appetite ________________________________________

**School History**

Please provide the following information about the schools your child has attended, starting with preschool or daycare and ending with the current school:

| Name of School | Grades | Reason for leaving |
| --- | --- | --- |
| e.g. Out of Doors School | 1st – 5th | transitioned to middle school |
| ______________________ | ___________ | ______________________________________ |
| ______________________ | ___________ | ______________________________________ |
| ______________________ | ___________ | ______________________________________ |
| ______________________ | ___________ | ______________________________________ |

Has your child ever repeated a grade? YES NO If yes, which grade(s)? ____________________

Has your child had learning problems in: ___preschool or kindergarten; ___elementary school; ___middle school; or ___high school? If yes, please describe ______________________________________
________________________________________________________________________________

Has your child received a psychoeducational evaluation? YES NO If yes, at what age, for what reason and by whom? ____________________________________________________________

Has your child ever received special education services or participated in the gifted program at his/her school? YES NO If yes, which grades and type of services? ______________________________
________________________________________________________________________________

Has your child ever received physical, occupational, or speech/language therapy at school? YES NO
If yes, which therapy, when, and how often? ______________________________________________

Does your child have trouble doing his/her schoolwork? YES NO If yes, please explain, and describe how much assistance your child requires to complete homework. ________________________
________________________________________________________________________________

What type of grades is your child currently making? ____________________________________
Have his/her grades been fairly stable? YES NO If no, when and how was his/her performance different?_______________________________________________________________

How does your child get along with his/her teachers? ___________________________________
Has he/she ever been suspended or expelled from school? YES NO
If yes, at what age and for what reason(s)? ______________________________________________
________________________________________________________________________________

Thank you for your thoughtful completion of this questionnaire! Your answers will help me to better understand your child and his/her unique strengths and weaknesses. If there is other information you would like to provide, please feel free to make additional comments on the back of this sheet.