310 Eisenhower Drive • Building 5
Savannah, Georgia 31406
info@savannahbehavior.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)

______ Seizure disorder or epilepsy

______ Other neurological disorder (e.g., stroke)

______ Bipolar Disorder

______ Autism/Aspergers Disorder

______ Thyroid disease

______ Genetic disorder (which one __________)

______ Schizophrenia

______ Other chronic illness (which one __________)

______ Speech/language difficulties

______ Drug or alcohol abuse

______ Learning disability (specify reading, math, etc.)

______ Repeated grade(s) in school

______ Mental retardation

______ Depression, anxiety, or other psychiatric illness

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.