CHILD DEVELOPMENT QUESTIONNAIRE

Name of CHILD/TEEN: _____ Today's Date: _____

Birth Date: _____ AGE: _____ GENDER: Female Male
Month Day Year

Your name: _____

Relationship to this child: _____

GENERAL INFORMATION

Biological Father's Name: _____ Age:___ Employed: ❒ Yes ❒ No

Type of Work: _____ Work Phone: _____

Address: _____ Home Phone: _____

Biological Mother's Name: _____ Age:___ Employed: ❒ Yes ❒ No

Type of Work: _____ Work Phone: _____

Address: _____ Home Phone: _____

Present Family Arrangement: ❒ Intact family ❒ Adoptive Family ❒ Single Parent
❒ Step-family ❒ Foster Family ❒ Separated Family
❒ Other _____

Please list everyone who lives with the child at this time:

Name	Relationship (i.e., mother, father, sister, brother, step-parent, step-sibling, etc.)	Occupation/Employer or School and Grade	Age

Who referred you to this agency?

❒ Self-referred ❒ Family member ❒ Family Doctor ❒ School ❒ Other

If not self-referred, please give the name and other information of the person who referred you:

Name: _____ Address: _____

Phone Number: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

Marital Status: ❒ Married ❒ Separated ❒ Divorced ❒ Common-law ❒ Single

How many years in relationship with other biological parent of this child: _____

Are you still with this partner? ❒ Yes ❒ No If No, date of separation: _____

Reason(s) for separation/divorce:

❒ Physical Abuse ❒ Sexual Abuse ❒ Emotional Abuse ❒ Affair

❒ Grew Apart ❒ Financial ❒ Other _____

How did child respond to separation/divorce? (Please check one)

❒ Better than you expected ❒ Like you expected ❒ Worse than you expected

Custody/Visitation Arrangements

Who has custody of the children? (Please check one)

❒ Mother ❒ Father ❒ Joint custody

❒ Other – Who? _____ ❒ Custody is currently in dispute

Please decribe visitation arrangements (i.e., how often, how long): _____

_____

Post Separation/Divorce Relationship

How would you describe your relationship with ex-partner: ❒ Good ❒ Fair ❒ Poor

Please explain:_____

_____

_____

How would you describe child's relationship with ex-partner: ❒ Good ❒ Fair ❒ Poor

Please explain:_____

_____

_____

What are you most concerned about regarding your child that led to this evaluation?

_____

_____

_____

When did you first notice these problems developing? _____

_____

_____

What have you and others tried to address these problems? _____

_____

_____

Are there family members on either side of the family (father's or mother's) who experienced similar problems? ❒ Yes ❒ No ❒ Not sure

If yes, please describe: _____

_____

Is there a family history of mental health problems? ❒ Yes ❒ No ❒ Not sure

If yes, please describe: _____

_____

Which of the following services has this child received?

Service	Agency/School/Practitioner	Date	For what problem
❒ Counselling/Therapy			
❒ Psychological Assessment			
❒ Psychiatric Assessment			
❒ Other (please describe): _____			

Have other family members received any of the services mentioned above? ❒ No ❒ Yes

If yes, list the name(s) of the family member(s), the type of service, and for which problem(s)

Name	Type of Service	Problem

Have any of the following happened to you, your child, and/or family?

History of family violence: ❒ Physical Abuse ❒ Sexual Abuse ❒ Spousal Violence
❒ Emotional Abuse ❒ Neglect ❒ Children Witnessed
Please explain: _____

History of Family Alcohol or Drug problems: ❒ No ❒ Yes
❒ Current; who and what? _____
❒ Past; who and what? _____

History of Sexual Victimization of Child: ❒ No ❒ Yes
If yes, please describe: _____

History of Psychiatric Problems: ❒ No ❒ Yes
If yes, please describe: _____

History of learning difficulties academic problems: ❒ No ❒ Yes
If yes, please describe: _____

History of Eating Disorder: ❒ No ❒ Yes
If yes, please describe: _____

History of Suicide/Previous Attempts: ❒ No ❒ Yes
If yes, please describe: _____

Significant losses/bereavement issues: ❒ No ❒ Yes
If yes, please describe: _____

History of Criminal Behavior: ❒ No ❒ Yes
If yes, please describe: _____

Financial Stress: ❒ No ❒ Yes
If yes, please describe: _____

PRENATAL AND BIRTH HISTORY

Place a checkmark (✓) beside any of the following problems that were experienced by the mother during this pregnancy:

		Please provide a brief description
❒	Lack of weight gain by mother	
❒	Excessive weight gain by mother	
❒	Nausea/Vomiting	
❒	Toxemia	
❒	Anemia	
❒	Elevated Blood Pressure	
❒	Swollen ankles	
❒	Kidney Disease	
❒	Bleeding	
❒	Measles	
❒	German Measles	
❒	Flu	
❒	Strep Throat	
❒	Other Virus	
❒	Other Illness	
❒	Prescription Medication	
❒	Accidents – Injury to Mother	
❒	Accidents – Injury to Father	
❒	Accidents – Injury to Other Children	
❒	Physical assault on mother by partner	
❒	Physical assault on mother by another family member	
❒	Physical assault by someone else (not related)	
❒	Pregnancy as a result of rape/incest	
❒	Emotional abuse of mother by partner	
❒	Emotional abuse of mother by another family member	
❒	Emotional abuse of mother by someone else (not related)	
❒	Financial Stress	
❒	Marital Stress	
❒	Workplace Stress	

Please provide a brief description

- ❒ Consumed Alcoholic Beverages _____
- ❒ Used “soft” drugs (i.e., marijuana, hashish) _____
- ❒ Used “hard” drugs (i.e., cocaine, heroin, lsd, etc.) _____
- ❒ Abused prescription drugs (i.e., tranquilizers) _____
- ❒ Exposed to second-hand smoke _____
- ❒ Partner consumed alcoholic beverages _____
- ❒ Partner used “soft”drugs _____
- ❒ Partner used “hard”drugs _____
- ❒ Personal Health Problems (i.e., heart disease, diabetes, etc.) _____
- ❒ Personality Change by Mother _____
- ❒ Personality Change by Father _____
- ❒ Depression – Mother _____
- ❒ Depression – Father _____
- ❒ Lack of support by partner _____
- ❒ Lack of support by partner’s family _____
- ❒ Lack of support by mother’s family _____
- ❒ Change of job during pregnancy _____
- ❒ Change of home during pregnancy _____
- ❒ Less than two years between pregnancies _____
- ❒ Inadequate housing (i.e., crowded) _____
- ❒ Problems with neighborhood (i.e., crime, pollution, violence) _____
- ❒ Problems with neighbors (i.e., conflict) _____
- ❒ Family member in trouble with the law _____
- ❒ Death of an immediate family member _____
- ❒ Death of a relative _____
- ❒ Death of a friend _____
- ❒ Loss of job _____
- ❒ You and partner separated _____
- ❒ Partner had an affair _____
- ❒ Other not mentioned above _____

Was this pregnancy planned? ❒ Yes ❒ No

While pregnant with this child, was the mother under a doctor's care? ❒ Yes ❒ No

Mother's age at Time of Birth: _____ yrs Father's age at Time of Birth: _____ yrs

Was this child born on schedule? ❒ Yes ❒ No

If no, approximately how many weeks early or late was the child? Weeks ____ ❒ Early ❒ Late

How many hours from first contraction to birth? _____ Was labor induced? ❒ No ❒ Yes

Delivery: ❒ Natural ❒ Caesarian Section ❒ Epidural ❒ Forceps/suction used

Please describe any complications:_____

_____

Birth weight: _____ APGAR Score (if known): _____

Any difficulties after birth (e.g., jaundice, breathing difficulties): ❒ No ❒ Yes

If yes, please describe: _____

How long in hospital after birth: Mother_____ Child_____

Did your child experience any of the following within the first year of life?

❒ Feeding Difficulties	❒ Sleep Difficulties	❒ Illness (describe)_____
❒ Accident/Injury	❒ Head Accident/Injury	❒ Breathing difficulties
❒ Blue Spells	❒ Colicky	❒ Little Weight Gain
❒ Excessive Weight Gain	❒ Seizures	❒ Excessive Shaking by Either Parent

Temperament (Infancy, Toddler, Pre-School): Check any that apply

❒ Shy or Timid	❒ Fearful	❒ Impulsive	❒ Rocking
❒ Stubborn	❒ Cautious	❒ Poor Sleep	❒ Headbanging
❒ Affectionate	❒ Underactive	❒ Curious	❒ Into everything
❒ Temper outbursts	❒ Overactive	❒ Tore up toys more than normal	
❒ Wanted to be left alone	❒ Easy to manage	❒ Slow to warm up to people	
❒ Dare-devil	❒ More interested in things than in people		❒ Happy
❒ Aggressive	❒ Poor eating	❒ Blank spells	❒ Falling spells

Overall, how would you describe your child's temperament?

❒ very easy ❒ easy ❒ average ❒ difficult ❒ very difficult

If "difficult" or "very difficult" please describe:_____

DEVELOPMENTAL HISTORY

Early Developmental Milestones

To the best of your knowledge, at what age did this child first accomplish the following?

Accomplishment	Years	Months	Not sure
Sitting without help	_____	_____	❒
Crawling	_____	_____	❒
First steps	_____	_____	❒
Walking alone, without help	_____	_____	❒
Babbling	_____	_____	❒
Using single words (e.g., mama, dada, ball, etc.)	_____	_____	❒
Putting two or more words together (e.g., mama up)	_____	_____	❒
Bladder training during the day	_____	_____	❒
Bladder training through the night	_____	_____	❒
Bowel training through the day	_____	_____	❒
Bowel training through the night	_____	_____	❒

Check and describe if your child had any problems with:

❒ balance _____

❒ walking _____

❒ running _____

❒ holding objects_____

❒ handwriting _____

❒ manipulating small objects_____

❒ using fasteners (buttons, zippers etc.)_____

Did your child receive occupational therapy or physiotherapy for any of the above problems?

❒ Yes ❒ No If yes, which one(s):_____

Are any of the above still a problem? ❒ Yes ❒ No If yes, which one(s):_____

_____

During the preschool years, how would you have rated the activity level of this child compared to other children his/her age?

❒ very active ❒ active ❒ average ❒ less active ❒ not active

How would you rate the activity level of this child now compared to other children his/her age?

❒ very active ❒ active ❒ average ❒ less active ❒ not active

MEDICAL HISTORY

Check if the child had the following illnesses and at what age:

Illness		Age		Illness		Age		Illness		Age
❒	Mumps	_____	❒	Chicken Pox	_____	❒	Ear infections	_____		
❒	Whooping Cough	_____	❒	Measles	_____	❒	Lead Poisoning	_____		
❒	Encephalitis	_____	❒	Scarlet Fever	_____	❒		_____		
❒	Seizures	_____	❒	Pneumonia	_____	❒		_____		
❒	Other Diseases (Specify):	_____								

Check if the child had any accidents resulting in the following injuries and at what age:

Injury		Age		Injury		Age		Injury		Age
❒	Broken Bones	_____	❒	Head Injury	_____	❒	Stomach Pumped	_____		
❒	Severe lacerations	_____	❒	Eye Injury	_____	❒	Sutures	_____		
❒	Severe Bruises	_____	❒	Lost Teeth	_____					
❒	Other injuries (Specify):	_____								

Has the child had chronic health problems with:

❒ Asthma ❒ Diabetes ❒ Heart Condition ❒ Stomach or digestive problems

❒ Others, please specify: _____

Does your child have any history of bedwetting or soiling their clothes? ❒ Yes ❒ No

If yes, please describe: _____

_____

Is this problem still occurring? ❒ No ❒ Yes If yes, how often? _____

Does your child suffer from any allergies? ❒ Yes ❒ No

If yes, please describe: _____

Date of last medical examination: _____ Dr.'s Name: _____

What were the results of the examination?: _____

_____

How is his/her hearing? ❒ Good ❒ Fair ❒ Poor

How is his/her vision? ❒ Good ❒ Fair ❒ Poor

How is your child's appetite? ❒ Good ❒ Fair ❒ Poor

❒ Overeats ❒ Eats too little

Does your child experience any problems sleeping?

❒ No ❒ Difficulty falling asleep ❒ Wakes up though the night

❒ Nightmares ❒ Early morning awakening ❒ Sleeps less than average child

MEDICATION HISTORY

List all medications that this child has taken or takes for medical or psychiatric problems:

Drug Name	Given by Whom	When Started	When Stopped	For What Problems	Results

Any side effects to medication? ❒ Does not apply ❒ No ❒ Yes

If yes, please describe: _____

_____

EDUCATION BACKGROUND

Name of School: _____ Grade_____

Teacher's Name:_____

List previous schools, dates attended and indicate overall academic performance and behavior:

Name of School & Grade	Academic Performance	Behavior
	❒ Poor ❒ Fair ❒ Good	❒ Poor ❒ Fair ❒ Good
	❒ Poor ❒ Fair ❒ Good	❒ Poor ❒ Fair ❒ Good
	❒ Poor ❒ Fair ❒ Good	❒ Poor ❒ Fair ❒ Good
	❒ Poor ❒ Fair ❒ Good	❒ Poor ❒ Fair ❒ Good
	❒ Poor ❒ Fair ❒ Good	❒ Poor ❒ Fair ❒ Good

For each school where you checked "poor" please describe the difficulties:

School	Difficulties
_____	_____
_____	_____
_____	_____
_____	_____

How does the school describe your child's classroom behavior? _____

_____

_____

Has your child ever repeated a grade(s)? ❒ No ❒ Yes If yes, grades(s) _____

Has the child ever been in any type of special education program? (Please note age or grade)

❒ Learning Disabilities Class____ ❒ Behavioural/Emotional Disorder Class_____

❒ Resource Room____ ❒ Speech and Language Therapy_____

❒ Other (please specify) _____

Has your child ever received a psycho-educational or academic assessment? ❒ No ❒ Yes

If yes, date of assessment and by whom: _____

Have you been told that your child has a learning disability? ❒ No ❒ Yes

If yes, who told you this and please describe the disability and any help that he/she is receiving for it: _____

_____

How far in school did each parent achieve?

Biological Father: ❒ Grade school ❒ High school ❒ College ❒ University

Biological Mother: ❒ Grade school ❒ High school ❒ College ❒ University

Overall, how was each parent's school experience?

Biological Father: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Biological Mother: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Please note anyone in the family (mother's or father's) who had learning problems:_____

_____

SOCIAL BACKGROUND

How many friends does this child have?_____

Does he/she make friends easily? ❒ Yes ❒ No If no, please explain: _____

_____

On average, how much time does this child spend with friends? _____

Place an "X" in the appropriate column to indicate how frequently this child gets along with:	Does Not Apply	Almost Always	Usually	Sometimes	Almost Never
His or her teachers					
Children at school					
Friends					
Brothers and sisters (including step and foster brothers and sisters)					
Parents					
Other adults					

Which of the following stressful events have happened to you or your family within the **past 12 months**?

❒ Parents divorced/separated ❒ Family accident illness ❒ Death in the family

❒ Parent changed job ❒ Changed schools ❒ Family moved

❒ Family financial problems ❒ Other (specify): _____

Does your child horde or hide food? ❒ Always ❒ Often ❒ Occasionally ❒ Never

Does your child lie? ❒ Always ❒ Often ❒ Occasionally ❒ Never

Does your child steal? ❒ Always ❒ Often ❒ Occasionally ❒ Never

How does your child handle his/her feelings/problems?

❒ Better than average ❒ Average ❒ Worse than average

Does your child belong to any clubs, activities? (ie. Cubs, Brownies, YMCA, etc.)

❒ No ❒ Yes

Club/Activity: _____

Note any problems:_____

Does your child have any hobbies? ❒ No ❒ Yes

Please list: _____

Apart from school, how does your child spend his/her day?

❒ Playing inside ❒ Playing outside ❒ Watching TV. ❒ Doing nothing

❒ Other, please specify: _____

How much television does your child watch each day?

❒ 1-2 hrs. ❒ 2-4 hrs. ❒ 4-6 hrs. ❒ 6-8 hrs. ❒ More than 8 hrs.

What kind of programs will he/she watch?

_____

_____

What responsibilities/chores does your child have? ❒ None ❒ Cleaning ❒ Dishes ❒ Meals

❒ Other, please specify: _____

How does he/she do in completing them?

❒ Always completes ❒ Sometimes completes ❒ Never completes

How does he/she respond when you make requests?

❒ Always appropriately ❒ Appropriately ❒ Never appropriately

When your child breaks a family rule, how do parents respond?

❒ Verbal reprimands ❒ Time out (isolation) ❒ Time out removal of privileges

❒ Rewards ❒ Physical Punishment ❒ Acquiescence to child

❒ Avoidance ❒ Other _____

Has your child ever broken the law? ❒ No ❒ Yes

If yes, please describe (charges, convictions, probation, etc.): _____

_____

_____

Please list/describe your child's strengths:

_____

_____

_____

_____

_____

_____

_____

_____

_____

If there is any additional information you feel we should know about your child, please describe below.

Thank you for completing this questionnaire!