Triangle Center for Behavioral Health
Lisa Ahern, Ph.D., PLLC
Developmental Questionnaire

Child's Name:______________________________ Age:________ Today's Date:___/___/___

Child's Sex:__________ Birthdate:____/___/______ Race:_______________________

Address:____

City:_________________ State/Province:________ Zip/Postal Code:_____________

How long has child lived at this address?_____________________

Person completing this form:________________________________ Relation to Child:____________

Please briefly state your concerns that led to you to arrange an evaluation:

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Who referred you here?

Name:______________________________ Address:____

Phone number:______________________

Demographic Information:

Parent/Legal Guardian's Name:_________________________________ Age:_________

Relationship to the Child: (mother, father, step-parent, grandparent, etc.)____________________

Biological Parent? ☐ Yes ☐ No (name/relationship of biological parent: ________________________)

Employer/Type of Work:________________________________ Education:___________

Work/Mobile Phone:______________________ Home Phone:______________________

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text reminders? ☐ Yes ☐ No

Email Address: ________________________________ ☐ Check if this person is primary contact

Parent/Legal Guardian's Name:_________________________________ Age:_________

Biological Parent? ☐ Yes ☐ No (name of biological parent: ____________________________)

Relationship to the Child: (mother, father, step-parent, grandparent, etc.)____________________

Employer/Type of Work:________________________________ Education:___________

Work/Mobile Phone:______________________ Home Phone:______________________

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text reminders? ☐ Yes ☐ No

Email Address: ________________________________ ☐ Check if this person is primary contact

Other Caregiver's Name:_______________________________________ Age:_________

Relationship to the Child: (mother, father, step-parent, grandparent, etc.)____________________

Biological Parent? ☐ Yes ☐ No (name/relationship of biological parent: ________________________)

Employer/Type of Work:________________________________ Education:___________

Work/Mobile Phone:______________________ Home Phone:______________________

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text reminders? ☐ Yes ☐ No

Email Address: ________________________________ ☐ Check if this person is primary contact

Who lives in the home with the child?:

Name/Age/Relation:______________________ Name/Age/Relation:_________________________

Name/Age/Relation:______________________ Name/Age/Relation:_________________________

Name/Age/Relation:______________________ Name/Age/Relation:_________________________

Siblings living outside of the home?:

Name/Age/Relation:________________________ Name/Age/Relation:___________________________

Name/Age/Relation:________________________ Name/Age/Relation:___________________________

If parents/legal guardians are divorced:

When was divorce?: _____________________

Who has custody? ☐ Parent Name: _____________ ☐ Parent Name: ________________

☐ Joint Custody ☐ Neither (explain): __________

Visitation agreement:______________________________________

Is this child adopted? ☐ No ☐ Yes, please describe the circumstances of the adoption:_____________

____

____

Is more than one language spoken in your home? ☐ No ☐ Yes, what is the primary language spoken in your home?: ____

<u>Pregnancy</u>: ***If don't know pregnancy history due to adoption, please check here:*** __________

Was the pregnancy with this child under a doctor's care? ☐ No ☐ Yes ☐ Don't know

Check any that apply for this pregnancy: Describe/Treatment

☐ Artificial Insemination/Donor ____

☐ Anemia ____

☐ Elevated Blood Pressure ____

☐ Toxemia ____

☐ Swollen Extremities ____

☐ Kidney Disease ____

☐ Bleeding/ Threatened Miscarriage ____

☐ Measles/German Measles ____

☐ Flu ____

☐ Strep Throat ____

☐ Other Virus/Illness/Injury ____

☐ Abnormal Nausea or Vomiting ____

☐ Medication(s) Taken ____

☐ Emotional Problems/Distress ____

☐ Premature Labor ____

☐ Smoked During Pregnancy ____________________

☐ Drank Alcohol During Pregnancy ____________________

Birth History: ***If don't know birth history due to adoption, please check here:*** ____

Mother's age at the time of child's birth: _______ Father's age at the time of child's birth: ________

Child's birth weight? _____lbs._____oz. Was birth a multiple?: ☐ No ☐ Yes, how many:_________

Was birth complicated by: Describe

☐ Prematurity ____________________

☐ Unplanned Induced Labor ____________________

☐ Breech presentation ____________________

☐ Cesarean section ____________________

☐ Unusual anesthesia ____________________

☐ Other ____________________

Following birth, were there complications related to:

☐ Breathing problems ____________________

☐ Need for oxygen ____________________

☐ Blue color ____________________

☐ Meconium ____________________

☐ Cord around the neck ____________________

☐ Jaudice/yellow color ____________________

☐ Feeding problems ____________________

☐ Maternal health ____________________

Did these complications result in an extended hospital stay? ☐ No ☐ Yes, how long:____________

Developmental History:

Motor Development (Sitting, Walking)	☐ Normal	☐ Fast	☐ Slow
Speech and Language	☐ Normal	☐ Fast	☐ Slow
Self-help Skills (dressing, toileting, hygiene)	☐ Normal	☐ Fast	☐ Slow
Handedness	☐ Right	☐ Left	☐ Both

Bowel Trained:	☐ Normal	☐ Fast	☐ Slow
Bladder Trained:	☐ Normal	☐ Fast	☐ Slow
Eating Behavior:	☐Picky	☐Average	☐ Over eats
Sleeping Behavior	☐ Normal	☐ More	☐ Less

Temperament (Infancy, Toddler, Preschool): Check all that apply:

Activity:	Emotional:	Interpersonal:
☐ Rocking/Head banging	☐ Shy or timid	☐ Affectionate
☐ Impulsive	☐ Fearful	☐ Distant/Hard to engage
☐ Daredevil	☐ Cautious	☐ More interested in things than in people
☐ Temper outbursts	☐ Happy	☐ Slow to warm up
☐ Overactive	☐ Curious	☐ Aggressive
☐ Into everything	☐ Irritable	☐ Clingy
☐ Easy to manage	☐ Sad	☐ Stubborn
☐ Hard on belongings		☐ Independent

Medical History

Has your child had any of the following?

	No	Yes	Date/Age/Description
Measles	☐	☐	______________________
Mumps	☐	☐	______________________
Rubella	☐	☐	______________________
Migraine	☐	☐	______________________
Severe Abdominal Pain	☐	☐	______________________
Cancer	☐	☐	______________________
Chicken Pox	☐	☐	______________________
Whooping Cough	☐	☐	______________________
RSV	☐	☐	______________________
Severe Flu	☐	☐	______________________
Strep Throat	☐	☐	______________________
Meningitis/ Encephalitis	☐	☐	______________________
Constipation	☐	☐	______________________
Urinary Tract Infections	☐	☐	______________________
Abscessed Ears	☐	☐	______________________

Tubes in Ears ☐ ☐ ____________________
Allergies ☐ ☐ ____________________
Asthma ☐ ☐ ____________________
Seizures ☐ ☐ ____________________
Head Injuries ☐ ☐ ____________________
Other Injuries ☐ ☐ ____________________
Hospitalizations ☐ ☐ ____________________
Hearing Problems ☐ ☐ ____________________
Vision Problems ☐ ☐ ____________________
Other ☐ ☐ ____________________

Does your child currently take medication for a medical illness? ☐ No ☐ Yes
If yes, please describe: ____________________

____

Does your child have known allergies to any medications? ____________________

____

Family Medical/Psychiatric History:

Have any of your child's **biological relatives** had physical health problems?
☐ No ☐ Yes ☐ Don't know
If yes, please describe whom/illness/treatment: ____________________

____

____

____

____

Have any of your child's **biological relatives** had mental health problems?
☐ No ☐ Yes ☐ Don't know
If yes, please describe whom/illness/treatment: ____________________

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Outside of biological relatives, are there **any other people with whom the child has significant contact** who have medical or psychiatric problems?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: ____

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Academic Information:

Current School:__________________________ Current Teacher/Grade:__________________________

Current Teacher's Email: ____

School's Address/Phone: ____

____

Type of school: ☐ Public ☐ Private ☐ Other ________________

Previous schools and grades attended	Academic Struggles?		Behavioral Struggles?	
________________________________	☐ Yes	☐ No	☐ Yes	☐ No
________________________________	☐ Yes	☐ No	☐ Yes	☐ No
________________________________	☐ Yes	☐ No	☐ Yes	☐ No
________________________________	☐ Yes	☐ No	☐ Yes	☐ No
________________________________	☐ Yes	☐ No	☐ Yes	☐ No

Repeated Grade?: ☐ No ☐ Yes: reasons: ____

____

____

Skipped Grade?: ☐ No ☐ Yes: reasons: ____

____

____

Behavior Consequences?

In-school Suspensions: ☐ No ☐ Yes: reasons:______________________________________

Out-school Suspensions: ☐ No ☐ Yes: reasons:____

Expulsions? ☐ No ☐ Yes: reasons:____

How do your child's teachers generally describe your child's behavior at school?____________________
____
____
____

Learning Difficulties/Strengths? ☐ No ☐ Yes (describe):

Has testing been completed? ☐ No ☐ Yes: results? (Please provide copies if possible):__________
____
____

Does your child have an IEP/504 Plan/accommodations: ☐ No ☐ Yes: details:________________
____

Does your child have a DEP/gifted services: ☐ No ☐ Yes: details:__________________________
____

What does your child like most/dislike most at school?____
____
____

Which of the following problems, if any, does this child have in school?

☐ Does not do homework	☐ Forgets assignments	☐ Below Average reading skills
☐ Fails to check work	☐ Many careless errors	☐ Below Average spelling
☐ Incomplete homework	☐ Incomplete classroom work	☐ Below Average math
☐ Not remaining seated	☐ Disorganization	☐ Below Average written language
☐ Inattention in class	☐ Talks excessively	☐ Below Average handwriting
☐ Distraction	☐ Anxiety	☐ Excessive time to complete work

Further comments on homework, academic functions:____________________________________
____
____
____
____
____
____

Psychosocial Functioning:

Which of the following, if any, describe(s) this child's interactions with peers?

☐ No friends ☐ Average number of friends ☐ Trouble keeping friends
☐ Few Friends ☐ Socially comfortable ☐ Trouble making new friends
☐ Controlling ☐ Aggressive ☐ Bullying
☐ Excessively shy ☐ Overall social ☐ Socially awkward

Extracurricular/Group Activities:____
____
____
____

Further comments on peer functioning:____
____
____
____

Therapy History:

Has your child ever received talk therapy? ☐ No ☐ Yes
If no, please go to medication questions.

If yes, please complete the following:

Has your child received Cognitive Behavioral Therapy (CBT)? ☐ No ☐ Yes ☐ Don't know

If yes, did it include assigned "homework"? ☐ No ☐ Yes ☐ Don't know

Provider	**Reason for treatment**	**Length of treatment**	**Outcome**

Has your child ever taken psychiatric medication? ☐ No ☐ Yes

If yes, please complete the following:

Medication	**Dosage**	**Dates of Use**	**Prescriber**	**Benefits**	**Side Effects**

Is there anything else you would like us to know about this child before we meet?

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