Dr. Shelley Goodwin Psychological Services, Inc

Developmental Questionnaire

The following information will help me to understand the child's needs, past history, and present situation. Please complete **ALL QUESTIONS**. Print the form and bring to your first session. Please feel free to write additional information on a separate piece of paper if you like.

Child's Full Name:____

Date of birth: ________________

Address: ____

Family doctor: _______________

Parent /Guardian: ________________________________ **Phone:** ____________

Address: ______________________________________ **Postal Code:** ________

Birth Mother: ___________________________________ **Phone:** ____________

Address: ______________________________________ **Postal Code:** ________

Birth Father: ___________________________________ **Phone:** ____________

Address: ______________________________________ **Postal Code:** ________

1. **What are your major concerns about your child?**
   - ____ development/learning problems
   - ____ attention problems (distractible, short attention span)
   - ____ activity level
   - ____ shyness
   - ____ non compliance (doesn't listen)
   - ____ problems getting along with ____ parents ____ peers ____ teachers

2. **Why would you like your child to receive a psychological assessment?**

____

____

____

4. **Who lives with the child?**

NAME	AGE	RELATIONSHIP WITH CHILD

5. **Mother's Occupation and Place of Employment:** ______________________________

   Father's Occupation and Place of Employment: ______________________________

DEVELOPMENTAL HISTORY

During pregnancy

Did the mother have:	No	Yes	If yes, explain	Months pregnant
Any illness or rashes?				
Any bleeding?				
X-rays taken? Which body part?				

Medications During Pregnancy	Dosage and other Details	Month(s) During Pregnancy
Type of Drug/Name of Drug		
Type of Drug/Name of Drug		

(←---------------------------------- check one ------------------------------→)

Alcohol	None	Daily	Weekly	Monthly
First 3 Months				
Second 3 Months				
Third 3 Months				

(←-------------- check one --------------→)

Tobacco Products	None	Daily	Weekly	Monthly	How much smoked each time?
First 3 Months					
Second 3 Months					
Third 3 Months					

DEVELOPMENT; Has your child started:

Motor Development	No	Yes	At age:
Holding up their head			
Reaching for toys			
Rolling over			
Sitting without support			
Crawling			
Walking without support			
Self-help development	**No**	**Yes**	**At age:**
Self-feeding with fingers			
Self-feeding with spoon			
Bladder / Bowel development	**No**	**Yes**	**At age:**
Bladder training: dry during day, pees at night			
Bladder training: dry during day and night			
Bowel training: poops in potty during day / diapers at night			
Bowel training: poops in toilet only, no diapers at night			

As a toddler was your child

Generally happy? Yes ____ No ___ Details ________________________________
Aggressive? Yes ____ No ___ Details ________________________________
Wiithdrawn? Yes ____ No ___ Details ________________________________
Hard to handle? Yes ____ No ___ Details ________________________________
Overactive? Yes ____ No ___ Details ________________________________

As a toddler, did your child

Sleep well? Yes ___ No ___ Details ____________________________
Eat well? Yes ___ No ___ Details ____________________________
Take pleasure in activities? Yes ___ No ___ Details ____________________________
Make friends easily? Yes ___ No ___ Details ____________________________
Throw tantrums? Yes ___ No ___ Details ____________________________
Hold his breath? Yes ___ No ___ Details ____________________________
Rock or bang his head? Yes ___ No ___ Details ____________________________
Have nightmares? Yes ___ No ___ Details ____________________________
Pick at skin? Yes ___ No ___ Details ____________________________
Have unusual fears? Yes ___ No ___ Details ____________________________
Destroy things? Yes ___ No ___ Details ____________________________
Seem shy? Yes ___ No ___ Details ____________________________

Fine Motor Development
Does your child prefer to use one hand more than the other? Yes ____ No _____
Which one is used most? _____________

Do you feel your child is well coordinated for his / her age in fine motor skills (drawing, cutting, handling toys)? Yes ____ No _____ If not please explain:

____

____

Gross Motor Development
Do you feel your child moves well for his / her age in gross motor skills (sitting, walking, jumping, balance)? Yes _____ No _____
If not please explain:

____

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____

General Development
Does your child have any unusual reactions to sounds, touch, movement, activities, smell, taste, vision, other? Yes _____ No _____
If yes please explain:

____

____

____

How does your child typically communicate? (check all that apply)

____ cries, screams, whines **____ noises** **____ actions, gestures**
____ 1 word utterances **____ 2-3 word phrases** **____ short sentences**
____ long sentences **____ detailed conversations**

Do you feel that your child speaks clearly for his / her age?
Yes ___ No ____
If not please explain:

____

____

____

Has your child had difficulty with managing food or liquid? E.g. sucking, drinking, biting, chewing, swallowing?
Yes ___ No ____
If not please explain:

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____

How does your child interact with people? E.g. quiet, shy chatty, etc.

____

____

____

Who does your child like to communicate with?

____

____

____

Health Concerns

Has your child had any of the following:

	Yes	No	Don't Know	If yes, explain
Seizures, epilepsy, convulsions				
Ear infections				
Hearing problems				
Hearing test				
Eye problems				
Vision test				
Feeding tubes				
Concussion				
Other medical problems				

Is your child on any medications at the present time? Yes ____ No ____

If yes, what is the name of the medication and dosage and who prescribed? ___________
____
____

List any illness, operations, or serious injuries for which your child has been hospitalized:

Illness/Operation/Injuries	Doctor	When	Hospital

Are any other professionals or agencies involved with your child (such as a psychologist, psychiatrist, speech-language pathologist, social worker, physiotherapist, occupational therapist, Mental Health staff, family & children services, or tutor)?

No _____ Yes _____ If yes, please complete below:

NAME	POSITION	ADDRESS	WHEN THEY LAST SAW YOUR CHILD

Have any of the child's brothers or sisters had problems in school? Yes ____ No_____
If yes, describe ____

____

Did either father, mother, or other relatives have problems in school? Yes ____ No_____
If yes, describe____

____

FAMILY MEDICAL HISTORY

Have any members of your family (e.g., parents, grandparents, aunts) had any of the following problems? Indicate relationship of family member to the child.

	Yes/No	Relationship	If yes, give details
Allergies			
Bedwetting/soiling			
Epilepsy/convulsions/seizures			
Mental retardation			
Emotional problems			
Drinking/drug problems			
Hearing/sight problems			
Learning problems			
Physical disability			
Speech problems			
Suicide			
Abuse/violence			
Mental illness			
Sexual abuse			
Other			

Please indicate the supports available to your child and family.
Other family members ____________________
Friends ____________________
Physician ____________________
Community agencies (e.g., Family & Children's Services, etc.) ____________________
Church/clergy ____________________
Other ____________________

(a) What are your child's strengths?

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____

____

(b) What are your family's strengths?

____

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Pre-School/Nursery/Daycare/Past Schools attended:

Name	Address	Dates attended	Teacher

Date completed ________________ Who completed this form _______________________