

# CHILDREN'S PROGRAM CHILD DEVELOPMENT QUESTIONNAIRE

Please complete and return BEFORE your scheduled appointment. This questionnaire provides historical information to assist us in a thorough evaluation/consultation. We see children of all ages with differing problems, so some questions may be irrelevant to your child. You may ignore questions that do not apply. This information is confidential and will be released only with a signed release of information to satisfy health insurance requirements, or in situations in which the law requires clinicians to make exceptions to confidentiality. THANK YOU.

Date \_\_\_\_\_ Person completing form \_\_\_\_\_ Relationship \_\_\_\_\_

1. **Child's full name** \_\_\_\_\_  M  F  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ Grade \_\_\_\_\_ Child lives with: \_\_\_\_\_

2. Parent #1 \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
 Married  Divorced  Other \_\_\_\_\_  
Address (if different) \_\_\_\_\_  
(street/P.O. Box) (city) (state) (zip)  
Email Address \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Parent #2 \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
 Married  Divorced  Other \_\_\_\_\_  
Address (if different) \_\_\_\_\_  
(street/P.O. Box) (city) (state) (zip)  
Email Address \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

3. Step-parent/significant other \_\_\_\_\_ Step-parent/significant other \_\_\_\_\_  
Age \_\_\_\_\_ Occupation \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

4. Children in the family, first-born to last, gender, age: Other people living in the home and their relationship  
1. \_\_\_\_\_ 1. \_\_\_\_\_  
2. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 3. \_\_\_\_\_

5. Has this child lived with persons other than parents? (If yes, please describe):  
\_\_\_\_\_

6. Has this child experienced (please give dates): Family Moves \_\_\_\_\_ Marital separation \_\_\_\_\_  
Divorce \_\_\_\_\_ Remarriage \_\_\_\_\_ Other \_\_\_\_\_

7. Who referred you to the Children's Program?  
\_\_\_\_\_

8. Have you received services from our clinic before?  YES  NO (If yes, please describe)  
\_\_\_\_\_

9. What brings you here today:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
HE

10. What questions would you like addressed by our evaluation/consultation for your child?  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

11. Are you or is anyone in your immediate family struggling with issues you would like to discuss?  
\_\_\_\_\_  
\_\_\_\_\_

12. Are you interested in a referral for yourself or a family member regarding any of these concerns?  
\_\_\_\_\_  
\_\_\_\_\_

13. Has anyone in your family had problems similar to your child's problems?  Yes  No (If yes, please describe):

14. Is there a family history of: (including extended family)

<input type="checkbox"/> psychiatric illness	<input type="checkbox"/> mental retardation/developmental disorders
<input type="checkbox"/> inherited medical condition	<input type="checkbox"/> emotional/behavioral disorders
<input type="checkbox"/> learning/language disability	<input type="checkbox"/> ADD/ADHD (attention problems, hyperactivity)
<input type="checkbox"/> drugs or alcohol use/abuse	<input type="checkbox"/> autism/spectrum disorders

15. Have you consulted with other agencies, clinics, or professionals about these concerns?  Yes  No  
(If yes, please describe): \_\_\_\_\_  
\_\_\_\_\_

16. Other problems? (If yes, please describe, including name(s) and treatment date(s)):  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

17. Has the child been affected by issues such as witnessing violence, having accidents, experiencing loss or abuse (physical, sexual, emotional)?  Yes  No

18. Please list your child's strengths/special talents and weaknesses as they relate to family:

<u>Strengths</u>	<u>Weaknesses</u>
1. _____	1. _____
2. _____	2. _____

19. Do your concerns about your child affect your marriage/relationships? Explain: \_\_\_\_\_  
\_\_\_\_\_

20. Additional information that would assist us in understanding your child:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION/HISTORY:** Child's physician(s) \_\_\_\_\_ Phone \_\_\_\_\_

Has your child seen a doctor within the last year? (If yes, please explain why):  Yes  No

Were there problems/concerns with  pregnancy  labor & delivery?  during the newborn period?

Has your child experienced:

- serious illnesses
- surgeries
- seizures
- chronic ear infections
- allergies
- hospitalizations
- injury or trauma to the head
- medical conditions we should be aware of

Are there concerns past/present about:

- diet/eating
- sleep
- bowel/bladder control
- drug/alcohol use

Has your child taken medication for behavior or psychiatric problems?   
Currently?  Yes  No   
Past?  Yes  No

Did you sign a release form so we may speak with your child's physician?  Yes  No

**EDUCATIONAL HISTORY:**

1. Current School District \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_   
Teacher \_\_\_\_\_ Phone #: \_\_\_\_\_

2. Has your child repeated any grades? Which grades? \_\_\_\_\_ For what reasons? \_\_\_\_\_

3. Please list each grade in which your child experienced significant difficulty or success and explain:

<u>Grade</u>	<u>Location</u>	<u>Explanation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. List any special educational or remedial services your child is currently receiving or has received in the past: \_\_\_\_\_

5. Please describe any current problems at school: \_\_\_\_\_

6. Have you spoken to the child's teacher or school counselor?  YES  NO (If yes, please describe) \_\_\_\_\_

7. Please describe any evaluation(s) done by the school and your understanding of the results: \_\_\_\_\_

8. Do you have concerns re:  grades  school performance  relationships with teachers  relationships with friends or peers in school

9. School staff person you would like us to contact regarding your child?

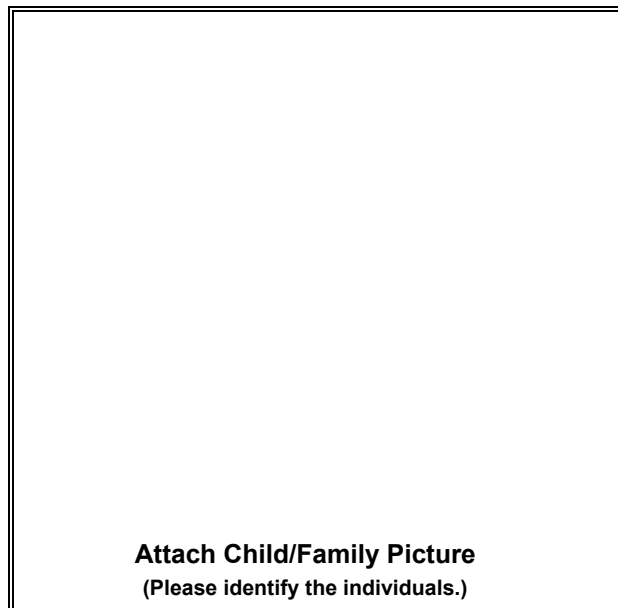
\_\_\_\_\_ Position: \_\_\_\_\_

**Did you sign a release form so we can speak with school staff?**  Yes  No

10. Anything else you would like to let us know? \_\_\_\_\_

\_\_\_\_\_

**PLEASE ATTACH COPIES OR BRING IN RELEVANT SCHOOL INFORMATION, REPORT CARDS, ETC.**



-----For Office Use Only-----

This information has been reviewed and considered in evaluation and treatment planning.

Clinician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Clinician's Signature \_\_\_\_\_

Date \_\_\_\_\_