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, while other information is required by insurance companies for chart review. 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.

Child/Patient's Name: _____ _____ B.D. _____
Last, First (Full Legal Name) (Name to Address Child)

Age _____ Grade_____ Gender Identity: ☐ M ☐ F ☐ Nonbinary ☐ Other _____ Birth Sex: ☐ M ☐ F

School _____

Person completing form: ☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Grandparent ☐ Other_____

Child lives with _____

Referred by (check all that apply): ☐ self ☐ physician ☐ client/friend ☐ school ☐ clinician ☐ insurance

Have you had services at the Children's Program before? ☐ No ☐ Yes

(if yes, describe) _____

CHILD AND FAMILY INFORMATION

1. Parent #1 _____ B.D. _____ Relationship to Client/Patient _____

   Address _____
   (street/P.O. Box) (city) (state) (zip)

   Email Address _____

   Cell phone _____ Other Phone _____

   Occupation _____

   Education (highest level completed): ☐ High School ☐ College ☐ Graduate Degree

   ☐ Married ☐ Divorced ☐ Living Together ☐ Other _____

   If divorced, what is the legal custody/arrangement _____

   Parent #2 _____ B.D. _____ Relationship to Client/Patient _____

   Address _____
   (street/P.O. Box) (city) (state) (zip)

   Email Address _____

   Cell phone _____ Other Phone _____

   Occupation _____

   Education (highest level completed): ☐ High School ☐ College ☐ Graduate Degree

   ☐ Married ☐ Divorced ☐ Living Together ☐ Other _____

   If divorced, what is the legal custody/arrangement _____

2. Are other adults involved in parenting? ☐ Yes ☐ No

   Name _____ DOB _____

   Relationship to patient _____

   Name _____ DOB _____

   Relationship to patient _____

Today's Date _____

List Children in family, first born to last:

1. Name _____ Age _____
2. Name _____ Age _____
3. Name _____ Age _____

Other people in household:

1. Name _____ Relationship _____
2. Name _____ Relationship _____
3. Name _____ Relationship _____

3. Has this child experienced (please list dates):

☐ Family Moves ☐ Marital separation ☐ Divorce ☐ Remarriage ☐ Other

4. What do you want to address in this consultation? _____

_____

_____

5. Have you sought treatment for medical/behavioral/educational concerns in the past? _____

_____

6. Tell us about your FAMILY HISTORY. Include those diagnosed or with significant characteristics.

	Mother	Father	Siblings	Grandparent	Aunt/Uncle	1st Cousins
Inherited/medical conditions						
Language learning disability						
ADD/ADHD						
Anxiety						
Autism Spectrum Disorder						
Sensory sensitivities						
Depression						
Schizophrenia						
Substance/alcohol abuse/addictive behavior						
Bipolar Disorder						
Criminal/legal involvement						
Past treatment for other conditions						

CHILD/PATIENT DEVELOPMENTAL HISTORY & MEDICAL INFORMATION

Name of Patient's physician: _____ Phone _____ Date of last visit _____

Name of Patients' other specialists: _____ Phone _____ Date of last visit _____

Name of Patients' other specialists: _____ Phone _____ Date of last visit _____

Were there problems/concerns with: ☐Pregnancy ☐Labor/ Delivery ☐During newborn period
If yes describe _____

Current Medications: _____

_____

List age developmental milestones were achieved:

Walking _____
Understanding language _____
Speaking single words _____
Speaking, putting two words together _____
Potty-Trained_____

Has this child experienced:

☐ Illness/hospitalization
☐ Surgery
☐ Seizures
☐ Chronic ear infections
☐ Allergies
☐ Weight loss/gain
☐ Injury/trauma to the head
☐ Serious illness
☐ Loss/death
☐ Medical condition we should be aware of
☐ Parents separation/divorce
☐ Remarriage
☐ Family moves
☐ Illness of family member
☐ Witnessing violence
☐ Physical/sexual abuse

Patient Name _____ DOB _____

Are there concerns about:

- ☐ Diet/eating
- ☐ Sleep: specify # of hours nightly ___
- ☐ Bowel/bladder control
- ☐ Sensory sensitivity
- ☐ Attention
- ☐ Physical complaints
- ☐ Stomach/headaches
- ☐ Tobacco/drug/alcohol use
- ☐ Electronics use
- ☐ Tiredness

SCHOOL HISTORY

Please list schools attended and successes/difficulties, repeated grades, teacher comments and other relevant information.

Level	Name of School	Experience
Preschool		
Grades K-3		
Grades 4 and 5		
Middle School		
High School		

Has your child had evaluations at school? Private clinics/agencies? Please describe:

School/clinic/agency	Date	Explanation

Has your child received special education/remedial services? ☐ Yes ☐ No If yes please explain:

Do you have concerns about:

- ☐ Grades
- ☐ School Performance
- ☐ Relationships with teachers
- ☐ Homework
- ☐ Relationships with peers/friends in school
- ☐ School Refusal
- ☐ Suspension/Expulsion

If yes, please describe:

Have you spoken to or met with:

☐ Child's Teacher ☐ Principal
☐ School Counselor ☐ Other ,specify: _____

What else should we know?

PLEASE ATTACH/BRING COPIES OF PAST EVALUATIONS, RELEVANT SCHOOL INFORMATION, REPORT CARDS, ETC.

Patient Name _____ DOB _____