**CONFIDENTIAL Health and Developmental Questionnaire** ­­

Student’s Name: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take a few minutes to answer the following items. The background information you provide will aid in the diagnosis and will be used to appropriately address your child’s needs. Thank You.

**A. Family History**

1. Parent Marital Status: Married Divorced Separated Widowed Single

2. Please indicate all the persons living in the home with the child. If siblings, please list age:

3. Language Spoken in the home: Parents\_\_\_\_\_\_\_\_\_\_\_\_\_ Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. Birth History**

1. Length of Pregnancy: \_\_\_\_\_\_ Weeks Duration of Labor: \_\_\_\_\_\_\_Hours

 Type of Delivery: Normal Cesarean Birth Weight/Length \_\_\_\_\_lbs. \_\_\_\_\_\_oz.

2. Did the mother receive prenatal care during pregnancy? Yes No

 If yes, when did care begin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Did the mother become ill/ hospitalized during this pregnancy? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Did the mother drink alcohol during this pregnancy? Yes No

5. Were there any complications during labor and delivery? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Were there any complications during your child’s first months of life? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Was he/she admitted into an intensive care nursery? Yes No

 Length of Stay \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Special care required\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did your child need surgery? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C. Developmental History**

1. At what **AGE** did your child:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Age |  | Age |
| Held head up |  | Simple sentences |  |
| Sat alone |  | Waved goodbye |  |
| Crawled |  | Fed self w/spoon |  |
| Pulled self up |  | Dry during the day |  |
| Walked alone |  | Indicated need to go to toilet |  |
| Single words besides mama & dada |  | Dry at night (occasional accident) |  |
| Dressed self (without buttoning) |  |

2. As an infant, did your child:

 Enjoy cuddling Yes No

Fall frequently Yes No Have trouble picking things up Yes No

 Poor coordination Yes No

 Colicky Yes No

 Have problems with weight gain Yes No

**D. Medical History**

1. Does your child have any difficulty with **vision**? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last vision exam:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 By Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you have any concerns about your child’s:

 Eating Yes No

Sleep Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does your child have (or has he/she had) any difficulty with **hearing**? Yes No

 With ear infections? Yes No

 Were tubes ever placed? Yes No

 Were antibiotics ever given to treat infection? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last hearing exam:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What type of healthcare professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Has your child ever received or is he/she currently on **special medication**? Yes No

 If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Has your child **ever** been seriously ill, hospitalized, or in an accident? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Is your child under a doctor’s care **now** for a health problem? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Does your child have a **history** of:

 High Fevers Yes No

 Asthma Yes No

 Bowel Problems Yes No

 Heart Condition Yes No

 Epilepsy/Seizures Yes No

 Eczema/Skin condition Yes No

 Neurological Problems Yes No

 Muscular/Motor Problems Yes No

**E. School History**

1. Has your child ever been enrolled in a preschool program? Yes No

Was he/she receiving any special help? Yes No

 If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Has your child been retained? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Has there been a problem with attending school regularly? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Has the child moved frequently? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Has your child ever received special help? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Does your child have problems at school with:

 Behavior Yes No

* If Yes, when did these problems begin:

Grades Yes No

* If Yes, when did these problems begin:

 Not wanting to go to school Yes No

**F. Social Behavior**

1. Describe your child’s **strengths**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Describe your child’s **weaknesses**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What activities does the child enjoy?

 Sports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. In his/her behavior and relationship with peers and adults, is your child:

 Aggressive Yes No

 Timid, shy, fearful Yes No

 Sensitive and cries easily Yes No

 Too quiet, withdrawn Yes No

 Does not like to play with other children Yes No

 Very active, can’t sit still Yes No

 Clings to adults Yes No

6. Does your child have trouble making friends? Yes No

7. Is your child’s behavior a problem at home? Yes No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**G. Difficulty as Observed by Parent(s)**

1. Does your child have difficulty explaining/describing things? Yes No

2. Does your child have trouble following directions? Yes No

3. Does your child speak in very short phrases? Yes No

4. Does your child have trouble understanding what he/she is told? Yes No

5. Do you have trouble understanding your child? Yes No

6. Does your child have trouble learning new concepts? Yes No

**H. Psychological History**

1. Has your child received counseling or therapy in the past or present? Yes No

 If yes, please briefly explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. Have there been any mental health diagnoses made in the past? Yes No

If yes, please briefly explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Is there family history of any mental health diagnoses (depression, anxiety, etc.) or suspected issues? Yes No

**I. Any other comments? (Please limit to this page)**