

**CHILD DEVELOPMENT QUESTIONNAIRE**

**GENERAL INFORMATION**

Name of Child \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_ Place of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_

Name of School \_\_\_\_\_ School Grade \_\_\_\_\_

School Address \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_

City State Zip  
Child's Legal Custodian  
Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other (specify) \_\_\_\_\_

List all persons with whom the child lives:

Name	Date of Birth	Age	Relationship to Child	Occupation or School Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List all immediate family members with whom child does not live:

Name	Age	Relationship to Child	Occupation or School Grade	City of Residence
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**PARENTAL INFORMATION**

	<u>Mother</u>	<u>Father</u>	<u>Other Parental Figure</u>
Name	_____		
Country of Birth (if not U.S.)	_____		
# of brothers/sisters in family	_____		
Religion	_____		
Relationship to Child (natural, step, adoptive)	_____		
Marital Status	_____		
# of previous marriages	_____		
Education (highest level completed)	_____		
If a parent is not living in the same house as the child, describe visitation, if any	_____		
	_____		
	_____		
If parents have been separated/divorced, give date of separation	_____		
	_____		

**DEVELOPMENTAL INFORMATION**

Pregnancy and Delivery

Was pregnancy planned? No\_\_\_ Yes\_\_\_

Any difficulties during pregnancy? No\_\_\_ Yes\_\_\_

Any difficulties during delivery? No\_\_\_ Yes\_\_\_

Birth Weight\_\_\_\_\_ Place of Birth\_\_\_\_\_

Any difficulties for mother after delivery? No\_\_\_ Yes\_\_\_

Specify\_\_\_\_\_

Any complications or illness at time of birth for child? No\_\_\_ Yes\_\_\_

Specify\_\_\_\_\_

Any significant family problems around time of birth? No\_\_\_ Yes\_\_\_

Specify\_\_\_\_\_

Any significant family problems in first two to three years of child's life? No\_\_\_ Yes\_\_\_

Specify\_\_\_\_\_

From birth to three years were any of the following present? Please circle

- 1. Head banging
- 2. Rocking
- 3. Much crying
- 4. Not cuddly
- 5. Temper tantrums
- 6. Convulsions
- 7. Overactive
- 8. Underactive
- 9. Colic
- 10. Allergies
- 11. Other (specify)\_\_\_\_\_

How would you describe your child during the first three years with regard to:

	Early	average	late	Specify what age
Walking	___	___	___	_____
Toilet training completed	___	___	___	_____
Talking	___	___	___	_____
	Easy	average	difficult	Specify age when difficult
Feeding	___	___	___	_____
Personality	___	___	___	_____
Sleeping	___	___	___	_____

Has your child ever appeared to be different from sisters or brothers? No\_\_\_ Yes\_\_\_

Specify how and at what age\_\_\_\_\_

Was child (0-5 years) placed in day care, nursery school, or with a babysitter? No\_\_\_ Yes\_\_\_

Specify at what age\_\_\_\_\_

Describe circumstances of any separations of child from a significant person lasting more than a month\_\_\_\_\_

Has your child experienced the death of a significant person? Explain\_\_\_\_\_

**MEDICAL HISTORY**

Child's doctor\_\_\_\_\_Address\_\_\_\_\_Phone\_\_\_\_\_

Is your child currently taking medication? No\_\_\_ Yes\_\_\_

Specify: Type of medication                      Dosage                      Duration                      Reason

\_\_\_\_\_

List any serious illnesses, allergies, handicaps, serious accidents or operations of the child and describe circumstances\_\_\_\_\_

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

List any relevant serious illness, allergies, handicaps, serious accidents or operations of immediate family members\_\_\_\_\_

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

Has anyone in the family received mental health services? Describe\_\_\_\_\_

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

Has anyone in the family had a problem with alcohol or substance abuse? Describe\_\_\_\_\_

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

**SCHOOL AND SOCIAL HISTORY**

Describe your child's degree of effort and level of achievement in school\_\_\_\_\_

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

How does your child get along with teachers?\_\_\_\_\_

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

Name of teacher (if in elementary or preschool) \_\_\_\_\_

If your child has been seen by any of the following personnel, please give names:

School psychologist \_\_\_\_\_

School social worker \_\_\_\_\_

Guidance counselor \_\_\_\_\_

Other \_\_\_\_\_

Please enclose copies of psychological assessment reports if available.

How does your child get along with other children at school? \_\_\_\_\_

\_\_\_\_\_

Does your child have any difficulties: making friends? No \_\_\_ Yes \_\_\_ keeping friends? No \_\_\_ Yes \_\_\_

If yes, what do you think makes it difficult for your child? \_\_\_\_\_

\_\_\_\_\_

Who ordinarily disciplines your child? Mother \_\_\_ Father \_\_\_ Both \_\_\_ Other \_\_\_ Specify \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What discipline do you find most effective? \_\_\_\_\_

\_\_\_\_\_

Does your child get along better with one parent than with the other? No \_\_\_ Yes \_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

Name any other adults, outside the family, with whom your child has an important relationship \_\_\_\_\_

\_\_\_\_\_

Describe how your children get along with each other \_\_\_\_\_

\_\_\_\_\_

What activities does your family enjoy together? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child held any job (full-time, summer, part-time)? No\_\_\_ Yes\_\_\_

If yes, type and duration of work\_\_\_\_\_

\_\_\_\_\_

How long has the child lived at the present residence? Years\_\_\_\_\_Months\_\_\_\_\_

Total number of changes of residence for child since birth?

None\_\_\_ 1-3\_\_\_ 4-6\_\_\_ 7-10\_\_\_ more than 10\_\_\_

**STRENGTHS**

What are your child's main strengths and good qualities?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you like most about your child?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If there is anything you consider important that is not covered in this questionnaire, please mention it here.