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Child Development Clinic

FAMILY QUESTIONNAIRE Appointment Date:_____

Today's date:_____Primary Phone Number_____

Child's name:_____Date of Birth:_____

Guardian: □ both parents □ mother □ father □ DSS □other_____

CURRENT CONCERNS

What are your primary concerns about your child?_____

_____

When did you first have these concerns?_____

_____

BIRTH AND EARLY INFANCY HISTORY

Age of mother at time of birth:_____Age of father at time of birth:_____

What pregnancy is this for mother? _____

Length of Pregnancy:_____

Any use of the following during pregnancy?

□ Drugs □ Alcohol □ Tobacco □ Prescription medications

If yes, please list medications/substances:_____

Please list any complications or problems during pregnancy:_____

_____

Labor and delivery: □ Vaginal □ C-section Birth Weight: _____

Were there any problems after birth (example: jaundice, need for oxygen, infections, feeding problems, seizures, etc.) □ Yes □ No If yes, please explain:_____

_____

Length of hospital stay after birth: _____

Were there any difficulties during infancy? (Example: excessive crying, "colic", vomiting, poor feeding): □ Yes □ No If yes, please explain:_____

_____

MEDICAL AND PHYSICAL HISTORY

Does your child have any allergies? □ Yes □ No If yes, please explain:_____

Is your child having any sleep issues? □ Yes □ No

□ restless □ snoring □ waking up at night □ difficulty falling asleep

Does your child have feeding issues? □ Yes □ No If yes, please explain: _____

_____

Has your child had their hearing tested? □ Yes □ No Results:_____

Has your child had their vision testing? □ Yes □ No Results:_____

Does your child have any history of hospitalizations, surgeries, or other chronic illness or sickness?

□ Yes □ No If yes, please explain:_____

_____

Medications

Please list all medications or supplements your child is currently taking.

Medication	*Dose*
_____	_____
_____	_____
_____	_____
_____	_____

THERAPY AND BEHAVIORAL THERAPY

Is your child currently receiving services through Early Intervention? □ Yes □ No

Is your child receiving therapy at an outpatient clinic? □ Yes □ No

Speech Therapy □ Yes □ No Occupational Therapy □ Yes □ No Physical Therapy □ Yes □ No

Is your child receiving counseling or behavior therapy? □ Yes □ No If yes, please list provider:_____

_____

Did your child have any attachment or bonding difficulties before the age of 5? □ Yes □ No

If yes, please explain: _____

Do you have concerns with how your child plays or interacts with other children?_____

_____

_____

What are your child's favorite activities?_____

_____

Do you have concerns with your child's behaviors? □ Yes □ No If yes, please describe:_____

_____

_____

SCHOOL

Is your child currently enrolled in school? □ Yes □ No

School: _____Grade:_____

Does your child have an IEP? □ Yes □ No

Does your child have a 504 plan? □ Yes □ No

Has the school expressed any behavioral or academic concerns? □ Yes □ No If yes, please describe:

_____

_____

DEVELOPMENTAL HISTORY: It may be difficult to remember these developmental milestones. Please do your best to answer as many as you can.

Social/Language	***Age Expected***	***Age Attained***
Smiles at parent	2 months	
Makes good eye contact	6 months	
Makes consistent sounds, babbles (for example: ba-ba)	6 months	
Responds to name	9-10 months	
Points to show something	12 months	
Plays peekaboo	12 months	
Says 1-2 words spontaneously	12 months	
Follows one step command without gesture	15 months	
Points to 6 body parts	18 months	
Speaks 2-3 word phrases	24 months	
Tells first name	36 months	

Did your child lose words? □ Yes □ No

Gross Motor	***Age Expected***	***Age Attained***
Sits alone	6 months	
Crawls on all 4s	7 months	
Walks alone (5 steps)	12 months	
Jumps with both feet	24 months	
Pedals tricycle	36 months	

Did you have difficulty changing your child's diaper due to stiffness? □ Yes □ No

Adaptive	*Age Expected*	*Age Attained*
Help with dressing	12 months	
Spoon feeds self	15 months	
Drinks from open cup	15 months	
Toilet trained	30 months	
Spears with fork	30 months	
Dresses self completely	36 months	
Buttons clothing	48 months	
Manipulates zipper	48 months	
Ties Shoes	6 years old	

HOME LIFE

Who lives at home with your child? (parent, siblings, grandparents, etc.) _____
_____

If in foster care, please explain the circumstances leading to foster care. _____
_____
_____

If parents are not together, please describe custody arrangements and visitation frequency. _____
_____
_____

Has your child been exposed to any particularly stressful experience such as bullying, inappropriate touch or abuse, violence, parental marital problems, or death of a loved one? If yes, please describe.

_____
_____

Biological Mother

Age: _____
Mental Health or Medical Problems: _____
Current Medications: _____
Highest Level of Education: _____
Occupation: _____

Biological Father

Age: _____
Mental Health or Medical Problems: _____
Current Medications: _____
Highest Level of Education: _____
Occupation: _____

Siblings:

Name	*Age*	*Problems*

FAMILY HISTORY

Please describe any medical or developmental concerns which occur in your child's (biologically related) family members. Consider immediate family in addition to more distant relatives such as grandparents, cousins, aunts.

Diagnosis/Condition	*Check if Applicable*	*Family Member* (*relationship to child*)
Autism		
ADHD		
Learning Difficulties		
Intellectual Disability		
Speech Delay		
Motor Delay		
Cerebral Palsy		
Bipolar Disorder		
Depression		
Anxiety		
Schizophrenia		
Seizures or epilepsy		
Genetic Disorder		

ADDITIONAL INFORMATION

Is there anything which you feel is important for this evaluation which you do not wish to discuss in front of your child? _____

_____

_____