# Developmental Questionnaire

## IDENTIFICATION
Child’s Name: ___________________________________________ Birthdate: _____________ Sex: ☐ Male ☐ Female Age: ______
Child’s Primary Care Physician: ___________________________________________ Person Completing this Form: ___________________________ Date: ________________ Relationship to Child: ___________________________________________

## STATEMENT OF THE PROBLEM
Describe as completely as possible the reason for referral / concern: ___________________________________________
When was the problem first noticed? ___________________________________________
Has your child received help for this problem? If so, what type? ___________________________
Where? ___________________________ When? ___________________________
What are your expectations for today’s visit? ___________________________________________

## GENERAL DEVELOPMENT
### A. FAMILY HISTORY
Please list siblings:

<table>
<thead>
<tr>
<th>NAME</th>
<th>SEX</th>
<th>DATE OF BIRTH</th>
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<tbody>
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</tbody>
</table>

Have any relatives (including parents, grandparents, siblings, aunts, uncles, cousins) had any of the following?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>IF YES, WHO?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental problem</td>
<td></td>
<td></td>
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<tr>
<td>Drug or alcohol problems</td>
<td></td>
<td></td>
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<tr>
<td>Hearing problems</td>
<td></td>
<td></td>
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<tr>
<td>Hyperactivity</td>
<td></td>
<td></td>
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<tr>
<td>Learning problems</td>
<td></td>
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<tr>
<td>Intellectual disability</td>
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<tr>
<td>Psychological problems</td>
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<tr>
<td>Seizures or epilepsy</td>
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<td></td>
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<tr>
<td>Severe behavior problems</td>
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<tr>
<td>Speech problems</td>
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</tbody>
</table>
Developmental Questionnaire – cont’d

Highest grade level attained by: Parent 1 _________ Parent 2 ________
Parent 1 occupation: __________________________________________
Parent 2 occupation: __________________________________________

What other languages are spoken in the home? __________________________________________
By whom are they spoken and how often? __________________________________________

Have there been any recent significant stress-producing events? □ Yes □ No
For whom? □ Parent □ Child
If yes, explain: __________________________________________

Do you or your child have any anxieties or fears related to your visit today? □ Yes □ No
If yes, explain: __________________________________________

B. PREGNANCY AND BIRTH HISTORY
Were there any complications, illnesses, accidents, or stress-producing events during pregnancy? □ Yes □ No
If yes, please explain: __________________________________________

Did the mother use prescription, non-prescription or street drugs, herbs, or alcohol during pregnancy? □ Yes □ No
If yes, please explain: __________________________________________

Was the baby born prematurely? □ Yes □ No
How many weeks early? ______________________________

Where was the baby born? _______________________________________ How long was the infant in the hospital? (days/months)________ _______

Were there any unusual problems at birth? □ Breathing difficulty □ Feeding difficulties
Explain: __________________________________________

Were there any bruises or abnormalities of the child’s head/body? __________________________________________

What did the baby weigh at birth? __________________________________________

What were the child’s APGAR scores? __________________________________________

C. MEDICAL HISTORY
Is the child now under the care of a doctor(s)? □ Yes □ No
Who?: ___________________________ Why?: ___________________________

Are immunizations up-to-date? □ Yes □ No

Is the child in pain? □ Yes □ No
If yes, please explain: __________________________________________

Is the child taking medication? □ Yes □ No
Type(s)? ___________________________ Why?: ___________________________

Is the child taking herbs? □ Yes □ No
Type(s)? ___________________________ Why?: ___________________________

Do you think hearing is normal? □ Yes □ No
Has child’s hearing ever been tested? □ Yes □ No
If so, when?: ___________________________
Where?: ___________________________ Results?: ___________________________

Do you think your child’s vision is normal? □ Yes □ No
Does your child wear glasses? □ Yes □ No

At what age did the following occur? Please explain.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age</th>
<th>Explain</th>
<th>Condition</th>
<th>Age</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenoidectomy</td>
<td></td>
<td>Eye Problems</td>
<td>Allergies</td>
<td></td>
<td>Heart Problems</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>High Fevers</td>
<td>Blood Disease</td>
<td></td>
<td>Meningitis</td>
</tr>
<tr>
<td>Chronic Colds</td>
<td></td>
<td>Muscle Disorder</td>
<td>Dental Problems</td>
<td></td>
<td>Nerve Disorder</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Seizures</td>
<td>Diabetes</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Ear Infections</td>
<td></td>
<td>Otitis Media</td>
<td>Encephalitis</td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

At what age did the following occur? Please explain.
Describe any other serious illnesses, injuries, physical problems, hospitalizations not mentioned above.

__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
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__________________________________________________________________________________________________________________________

D. DEVELOPMENTAL HISTORY

At what age did the following occur?

<table>
<thead>
<tr>
<th>Held head up:</th>
<th>Rolled over:</th>
<th>Sat alone unsupported:</th>
<th>Crawled:</th>
<th>Walked Alone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weaned from bottle:</td>
<td>Said first words:</td>
<td>Put words together:</td>
<td>Was toilet trained:</td>
<td>Followed simple directions:</td>
</tr>
</tbody>
</table>

How much of the child’s speech do you understand?  
☐ 0%  ☐ 10%  ☐ 25%  ☐ 50%  ☐ 75%  ☐ 100%  ☐ Too young to talk

Check these as they applied / apply to the child:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>EXPLAIN (give age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally indifferent to sound</td>
<td></td>
<td></td>
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<tr>
<td>Does not respond when spoken to</td>
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<td></td>
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<tr>
<td>Responds to noises, not speech</td>
<td></td>
<td></td>
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<tr>
<td>Irregular sleep pattern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty sucking</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty chewing</td>
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<td></td>
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<tr>
<td>Difficulty swallowing</td>
<td></td>
<td></td>
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<tr>
<td>Prefers soft foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive drooling</td>
<td></td>
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<tr>
<td>Food comes out nose</td>
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</tbody>
</table>

Has the child ever been diagnosed with:

<table>
<thead>
<tr>
<th>√</th>
<th>BY WHOM</th>
<th>WHEN</th>
<th>DO YOU AGREE?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Autism Spectrum Disorder</td>
<td></td>
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<tr>
<td></td>
<td>Cerebral Palsy</td>
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<tr>
<td></td>
<td>Developmental Syndrome</td>
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<td></td>
<td>Fine Motor Problem</td>
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<td></td>
<td>Gross Motor Problem</td>
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<tr>
<td></td>
<td>Head Injury</td>
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<td></td>
<td>Hearing Loss</td>
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<td>Learning Problem</td>
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<td></td>
<td>Intellectual Disability</td>
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<tr>
<td></td>
<td>Neurological Problem</td>
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<tr>
<td></td>
<td>Speech and/or Language Problem</td>
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<tr>
<td></td>
<td>Visual Impairment</td>
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<td></td>
<td>Other (specify)</td>
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</tbody>
</table>
Mark any evaluations or therapy received. If received by the child, mark a “C”; if received by another family member, mark an “F”.

- Speech-Language
- Occupational Therapy
- Behavioral
- Psychological
- Physical Therapy
- Hearing
- Counseling
- Nutritional
- Parent Training
- Educational
- Developmental

Describe results:

__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

E. SOCIAL BEHAVIOR
Check these if they apply to the child:

- Floppy when held
- Aggressiveness
- Separation difficulties
- Tense when being held
- Biting
- Difficulty getting along with children
- Resists being held
- Injures self
- Difficulty getting along with adults
- Cries a lot, irritable, fussy
- Lives in a world of his/her own
- Difficulty staying with an activity
- Underactive
- Rocking
- Toilet training problems
- Overactive
- Prefers to play alone
- Difficult to discipline

How do you discipline the child?

__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

Describe any behavior that is a problem to the parents:

__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

F. EDUCATIONAL HISTORY
Did / Does child attend day care or preschool?  □ Yes  □ No  Where? __________________________

School now attending: __________________________  Grade: __________________________

- Regular Education
- Special Education
- Therapy Services
- In-home Program

Performance: __________________________

__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

Does the child remember homework instructions?

__________________________________________________________________________________________________________

Does the child follow directions in school?

__________________________________________________________________________________________________________

Does the child retain information taught?

__________________________________________________________________________________________________________

What is your impression of the child’s learning abilities?

__________________________________________________________________________________________________________

Does your child have a current IEP or IFSP?  □ Yes  □ No  Where? __________________________

What would you like to accomplish for your child through this assessment process?

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