

## DEVELOPMENTAL QUESTIONNAIRE:

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

1. Was the child planned? YES / NO. If the child was not planned, please describe the circumstances around the pregnancy:
  
  
  
  
  
  
  
  
  
  
2. What were the mother's reactions to the pregnancy (nervous, apprehensive, unusually happy, moody, other...) Please describe:
  - a. Physical conditions:
  
  
  
  
  
  
  
  
  
  
  - b. Medicine prescribed during pregnancy? Please list:
  
  
  
  
  
  
  
  
  
  
  - c. Nausea?
  
  
  
  
  
  
  
  
  
  
  - d. Illness of any kind?
  
  
  
  
  
  
  
  
  
  
  - e. Any accidents, falls? Describe:
  
  
  
  
  
  
  
  
  
  
  - f. Any use of substances (cigarettes, alcohol, marijuana, others, etc...)?
  
  
  
  
  
  
  
  
  
  
3. What were the mother's activities during pregnancy?
  
  
  
  
  
  
  
  
  
  
4. What were the mother's living situation & events in the home during the pregnancy?
  
  
  
  
  
  
  
  
  
  
5. What was the father's attitude toward the mother about being pregnant & during her pregnancy? Please elaborate:

6. Approximately how long was the mother in labor? \_\_\_\_\_ hours.  
Was labor induced? YES / NO Was labor difficult or easy? YES / NO  
Please explain:

Were forceps used? YES / NO  
Other Comments:

7. What was the father's attitude toward the birth of the child?

8. Weight of the baby at birth \_\_\_\_\_ lbs. \_\_\_\_\_ oz.  
Was the baby full-term? YES / NO  
If not, how much earlier or later than the expected date of arrival? \_\_\_\_\_

9. Did the baby breath spontaneously and easily? YES / NO  
Did he/she need oxygen and other medical assistance after delivery? Please describe:

10. Was there anything exceptional in the baby's condition, such as injury, paralysis, blueness, excessive crying...?

11. Did the mother have convulsions, hemorrhages, infections, unusual nervousness, tears, or anything else at or soon after childbirth? Explain:

12. Was the baby breast-fed? YES / NO Bottle fed? YES / NO  
Or received both types of feeding? \_\_\_\_\_

a. If breast-fed (partially or completely), did the mother experience any difficulty with: scanty milk supply, nursing pain, cracked or inverted nipples?

b. What was the baby's response to nursing?  
Active Eager Had to be encouraged

c. What were the mother's feelings about the nursing experience?

13. Were there times when the baby had frequent colic, constipation or diarrhea?

YES / NO At what ages?

How was this handled?

14. What attitude or mood did the baby seem to express most of the time? (Example: happy, cuddly, whiny, sad, frustrated...)

15. Did anyone assist the mother in the care of the baby? YES / NO

Mother-in-law \_\_\_\_\_, Mother \_\_\_\_\_, Other \_\_\_\_\_.

16. Generally, babies vary in regard to the amount of activity they show. Which of the following do you think most nearly describes your baby during his/her first few months? (*Circle one below*).

- a. Showed a great deal of activity such as squirming, wiggling, kicking, and otherwise moving about so that it caused concern or difficulty.
- b. Showed very little physical activity, not even showing any interest in movement or response when hungry or when played with.
- c. Showed vigorous activity when awake and when played with, but was equally often observed playing quietly and generally relaxed.

17. During the baby's first year of life was there anything (even if it had nothing to do with the baby) that caused unhappiness or anxiety or placed the mother or father under special stress/strain? Please describe:

18. Do you remember when the child was growing up if he/she had a particularly favorite toy or stuffed animal? YES / NO

Describe:

19. Has the child ever had angry outbursts, temper tantrums, or other kinds of behavior that caused you concern?

20. (Mark ALL that apply) Has the child ever screamed? \_\_\_\_\_ Stomped? \_\_\_\_\_ Thrown things? \_\_\_\_\_ Thrown him/herself on the floor? \_\_\_\_\_ Hurt others? \_\_\_\_\_ Hurt him/herself? \_\_\_\_\_ Held his/her breath? \_\_\_\_\_ Banged his/her head on things? \_\_\_\_\_ Describe the appearance of the child during these situations:

21. What methods have you used in disciplining?

- a. Spanking?
- b. Withholding of privileges?
- c. Withholding of approval and showing of affection?
- d. Others? Please describe:

22. How does the child react to discipline generally?

23. Has discipline been frequently necessary?

24. Who ordinarily disciplines the child?

25. Have the parents agreed with each other on the methods of discipline and privileges or have there been disagreements?

26. During the early years of the child's life, was either parent frequently away or out of the home?

27. Has the child ever expressed fear of: darkness, dogs, trains, elevators, etc...? Please explain.

28. Has the child had frightening dreams? YES / NO  
At what age(s)?

29. Does the child have any night disturbances? YES / NO  
Problems going or staying asleep, sleep-walking, night terrors, etc.? YES / NO  
Please explain:

30. Has the child ever had daydreams? YES / NO    Fantasies? YES / NO  
Imaginary Friends? YES / NO  
At what age(s)? \_\_\_\_\_

31. Has the child ever lost any person with whom he or she seemed to have a close relationship with (such as a family member, grandparent, or other)? YES / NO  
At what age(s)? \_\_\_\_\_

32. Has the child ever seemed reluctant to be left in the care of others or objected to it?  
Please explain:

33. How does your child get along with his/her siblings?

34. Did the child have any preschool or school experiences, such as nursery or kindergarten, in which separation from the home was difficult for him/her? YES / NO Please explain:

35. (*Circle those that apply*) Currently, does he/she prefer playing with children of his/her own age? YES / NO    Older?    Younger?  
Does the child have more than one friend? YES / NO

36. Does the child seem to have a closer attachment to one parent than the other?  
YES / NO    Which one? \_\_\_\_\_  
Was there any changes in the attachment, and if so, when?

37. Has the child ever required his/her parents to do things for him/her that he/she was capable of doing for himself/herself? YES / NO Please explain:

38. Has the child ever had strong likes and dislikes for food? YES / NO  
What types of food?

39. Has the child ever had any frightening experiences? YES / NO  
Describe the experience(s) and the child's reactions:

40. At what age did your child begin school? \_\_\_\_\_

41. Has your child ever skipped one or more grades? YES / NO  
Has been retained? YES / NO  
If yes, why?

42. Does your child play with other children at school? YES / NO

43. How much time does your child spend studying?

44. Circle the word/words that best describe your child's grades throughout his/her school experience:

Superior

Average

Below Average

Failing

45. Describe your child's attitude toward school when he/she first started:

What is his/her attitude now?

46. Has your child ever had any coordination difficulties such as confusion in regard to left-handedness, or right-handedness, or frequent falling, or awkwardness?

47. List the illnesses the child has had. State at what age each occurred, how long each lasted, and what treatment was given:

Illness                      Age                      How Long?                      Treatment Given

48. Has your child had any operations? If so, state at what age, how long they were hospitalized, and if there were any complications:

Operation                      Age                      Hospitalization                      Complications                      Child's Reactions

49. Is your child on any medication at the present time?

Medication                      Prescribed for?                      Taken for how long?

50. Why have you brought your child in for services at this time?

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Thank you for taking the time to completely fill out this questionnaire.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_