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Developmental History Questionnaire

To be completed for patients of Dr. Renee Peacock's, who are 17 years old or younger.

CHILD'S NAME: ______________________________ **DATE:** ________________

DATE OF BIRTH: ______________________________ **AGE:** ________________

INFORMANT: ______________________________ **RELATIONSHIP:** ___________

PRENATAL HISTORY

Mother's health during pregnancy: ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Age of mother at child's birth ___________

If there were complications during pregnancy, please describe:

Were any of the following medications or substances used during pregnancy?

Alcoholic beverages Frequency: ____

Caffeine (coffee, tea, soda) Frequency: _____

Cigarettes Frequency: _____

Other medications (Please explain): ____________________________________

If there were complications during delivery, please explain:

Was your child born at ☐ Full term, ☐ ____weeks early, ☐ ____ weeks late?

Type of delivery: ☐ Vaginal ☐ Caesarean section ☐ Induced ☐ Forceps used

Child's birth weight: ______________________

Child's condition at birth: ☐ Good ☐ Fair ☐ Poor ☐ Don't know

Did your child require a stay in the NICU? Please describe if so:

EARLY DEVELOPMENT

Did your child experience any medical problems during infancy? ☐ No ☐ Yes
If yes, please describe:

Was your child an easy baby, meaning did he or she cry often or follow a schedule fairly well? ☐ Very easy ☐ Average ☐ Difficult ☐ Very Difficult

During childhood, did he or she have problems with any of the following?

☐ Hearing ☐ Vision ☐ Speech ☐ Gross motor skills (running, climbing, riding a bike)

☐ Fine motor skills (tying shoes buttoning, coloring, handwriting) ☐ Social Skills

If any of the above categories were checked, please explain:

MEDICAL/HEALTH STATUS

Has your child had any significant health or medical problems? (chronic condition, surgery, injury, hospitalization)? ☐ No ☐ Yes If yes, please explain:

Has your child had any significant head injury or injury when he or she lost consciousness? ☐ No ☐ Yes If yes, please explain:

Does your child take any medications regularly? ☐ No ☐ Yes If yes, please provide name of medication(s), physician who prescribed medication, and duration of use.

Has your child been evaluated or treated by a mental health professional previously? ☐ No ☐ Yes If yes, please provide relevant information:

Does your child have any problems with sleep? ☐ No ☐ Yes   If yes, please describe:

Child's bedtime: ________________   Usual number of hours of sleep: _________

Child sleeps alone: ________   Child sleeps with: _______________________________________

EDUCATIONAL HISTORY

Name of child's current school: ____________________________________ Grade: _________

Number of schools your child has attended: _____________

Number of grades repeated: __________________

Has your child been evaluated or special education services? ☐ No ☐ Yes
If so, please explain below and bring copies of testing and any IEP's that may have been developed as a result.

Current academic performance: ☐ Very Good (All A's & B's)
☐ Fair (C's)
☐ Poor (Mostly D's & F's)

Is your child currently being tutored outside of school? ☐ No ☐ Yes
If yes, please describe services received and frequency:

SOCIAL SKILLS AND ACTIVITIES

How does your child get along with family members and others?

Parents: ☐ Very good ☐ Average ☐ Fair ☐ Poorly

Siblings: ☐ Very good ☐ Average ☐ Fair ☐ Poorly

Peers: ☐ Very good ☐ Average ☐ Fair ☐ Poorly

Does your child have a best friend or a group of friends with whom he often socializes? ☐ No ☐ Yes

PLEASE BRING A COPY OF THIS COMPLETED FORM TO THE INITIAL VISIT

Print Form   Clear Form