Create A Healthy Mind
Child Developmental History Questionnaire
SJParks,Ph.D.

Child's Name: _____ DOB: _____ Age: _____
School: _____ Grade: _____
Primary Teacher or Contact: _____
Name of Person filing out form: _____ Relationship: _____

CURRENT AREAS OF CONCERN TO PARENTS OR CARETAKERS

Please briefly describe current areas or issues that are difficult for your child:

a. _____
b. _____
c. _____
d. _____

How long have these issues been a concern (since what age)?

a. _____
b. _____
c. _____
d. _____

What has been done to help with these difficulties?

a. _____
b. _____
c. _____
d. _____

Please describe any stressful events or situations that are currently going on in your child's life either at home or elsewhere:

a. _____
b. _____
c. _____
d. _____

SCHOOL RELATED ISSUES:

Age child started in daycare setting: _____ NA _____
Age child started formal schooling: _____
Any difficulties adjusting to daycare or formal schooling? Yes_____ No _____
Please Explain:
_____
_____

 CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

Is your child having any current difficulties in school? _____ If so, please explain:

a. _____
b. _____
c. _____
d. _____

Please document any changes in schools:

First Placement: _____ from_____ to _____
Changed to: _____ from _____ to _____
Changed to: _____ from _____ to _____
Changed to: _____ from _____ to _____

Average Grades in Various Subjects Current Year:

E (excellent) VG (very good) G (good) F (fair) P (poor) F (failing)

Math: _____
English/Language Arts: _____
Writing: _____
Reading: _____
Science: _____
Social Studies/History: ____
Art: _____
Music: _____
PE: _____

Average Conduct Grade in School: _____

Do you feel that the above grades are representative of your child's potential? Y___ N___
If no, why not: _____
_____

How to you feel about your child's progress in school? _____
_____
_____

 CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

Please list your child's academic and personal strengths as you see them:

a. _____
b. _____
c. _____
d. _____
e. _____

What weaknesses do you see in your child as a student and as a person?

a. _____
b. _____
c. _____
d. _____

Do you think that your child may be gifted in comparison to his/her same age peers?

Yes ____ No _____

If so, in what areas?

a. _____
b. _____
c. _____

Do you think that your child may have learning differences? Yes _____ No _____

If so, in what areas?

a. _____
b. _____
c. _____

Is he or she in any special class placements? Yes ____ No _____

What are his special classes called?

a. _____
b. _____
c. _____

What was the date of your child's last psycho-educational or psychological evaluation? _____.

Who performed the evaluation:? _____

Please describe the main results:

_____
_____
_____

Page Four CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

Please list any identified diagnoses that have had an impact on your child's school performance:

a. _____
b. _____
c. _____

SOCIAL HISTORY

How well does your child currently get along with his or her same age peers? (check one)

Exceptionally Well _____ Very Well _____ Fairly Well ____ Not too well _____ Disastrously ____

How many friends does your child play with on a regular basis? _____

Does your child have a 'best friend'? Yes _____ No_____

If so, what kinds of things do they like to do together:

_____

Describe any difficulties that your child has getting along with same-age peers:

_____

Who resides in the home with your child (including parents!):

a. name: _____ Relationship: _____ Age: ____
b. name: _____ Relationship: _____ Age: ____
c. name: _____ Relationship: _____ Age: ____
d. name: _____ Relationship: _____ Age: ____
e. name: _____ Relationship: _____ Age: ____
f. name: _____ Relationship: _____ Age: ____
g. name: _____ Relationship: _____ Age: ____

Any difficulties getting along with siblings? Yes _____ No _____

If so, please describe:

_____
_____

 CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

Please describe any difficulties in the parent-child relationship:

a. _____
b. _____

Biological parents names and ages (if different than the parents living in the home):

a. Name: _____ Age: _____
b. Name: _____ Age: _____

Please list names and ages of any stepparents not living in the home:

a. Name: _____ Age: _____
b. Name: _____ Age: _____

Please list any situations in the past that you feel may have been traumatic for your child:

a. _____
b. _____
c. _____

How well do you feel that these situations have been resolved?

a._____
b._____
c. _____

To the best of your knowledge, has your child ever been physically or sexually abused?

Y____ N_____ Please explain and give approximate dates: _____
_____
_____
_____

BIRTH AND EARLY DEVELOPMENTAL MILESTONES

Describe any difficulty with this pregnancy or stresses on mother while pregnant with this child:

_____
_____
_____
_____

 CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE-

Describe anything that stood out about the birth process or any difficulties with the birth process:

_____
_____
_____

Please describe any difficulties with eating, sleeping or toileting during the first few months of life:

Eating: _____
Sleeping: _____
Toileting: _____

Approximate birth weight: _____lbs _____oz.

Was your child ever breastfed? Y _____ N_____ if so how long: _____

At what age did he or she start using a bottle: _____

Please describe any feeding/eating difficulties after the first few months:

_____
_____

Please describe any special dietary restrictions along with reason for them:

_____

Please describe any difficulties falling or staying asleep and ages of occurrences:

_____
_____

Approximate age your child first walked unassisted:

_____ yrs _____mos.

Approximate age of first spoken word: _____yrs. _____mos.

Approximate age when child used two or more word sentences to communicate effectively:
_____ yrs. _____mos.

 CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

Any difficulties learning to talk? Yes ____ No ____
Please explain: _____
_____

Approximate age toilet training began _____yrs _____mos.; and
ended: _____yrs _____mos.

Please describe any significant difficulties with the toileting process:
_____
_____

Any current difficulties with toileting (e.g. wetting at night, soiling, staining)?

Y_____ N _____ If yes, please explain:_____
_____
_____

What has been tried to remedy this problem: _____
_____

Has your child ever been separated from either parent for over one month? Y _____
N _____ Please explain and give dates: _____

MEDICAL HISTORY

Does your child have any visual or perceptual problems (that you know of)?

Y _____ N _____ Please explain: _____
_____

Does your child need glasses to read? Y _____ N _____

Does your child have adequate hearing? Y _____ N _____

Please list any significant illnesses or injuries along with dates of occurrences:

Illness/Injury: _____ dates _____
Illness/Injury: _____ dates _____
Illness/Injury: _____ dates _____
Illness/Injury: _____ dates _____

 CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

What medications does your child take on a regular basis?

Med: _____dose_____frequency: _____
Med: _____dose _____frequency: _____
Med: _____ dose _____frequency: _____

Is your child RIGHT or LEFT handed (Please circle one)

Pediatrician's name and phone number:
_____# _____
name phone number

What vitamins, herbs or nutritional supplements does your child take on a regular basis:

a. _____
b. _____
c. _____

Does your child have any known food or environmental allergies?
Y _____ N _____
If yes, what are they?

a. _____
b. _____
c. _____

Please describe what changes occur as a result of these allergens:

a. _____
b. _____
c. _____

To the best of your knowledge, has your child ever witnessed or suffered any physical, emotional or sexual abuse? Y _____ N _____

How well do you feel these situations been resolved? Please explain:
_____
_____
_____
_____

How do you think these situations affect your child today?
_____
_____

 CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

FAMILY HISTORY

Which person in your family does your child most remind you of and why?

Who?_____ Why?_____
_____
_____

Who is your child most likely to turn to when upset? _____

To the best of your knowledge, have any of your child's biological relatives ever suffered from any of the following problems (circle all that apply and tell relationship to relative)

Bipolar disorder
Schizophrenia
Major depression
Personality disorder
Anxiety disorder
Phobias
Explosive temper
Sexual abuse
Physical abuse
Alcoholism
Drug addiction
Incarceration
Hospitalization for a mental disorder
Learning differences/learning disability
Attention deficit disorder with or without hyperactivity
Organic brain injury
School failure
Behavioral problems in school
Dyslexia
Anorexia
Bulemia (uncontrollable binge eating)

Problem:	Relationship:
_____	/ _____
_____	/ _____
_____	/ _____
_____	/ _____
_____	/ _____
_____	/ _____
_____	/ _____

SPECIAL CONCERNS OF PARENTS NOT ADDRESSED SUFFICIENTLY:

Do you have any other concerns that you would like me to be aware of?

_____
_____
_____
_____
_____
_____
_____
_____

What are you hoping that your child will get out of this evaluation or therapy?

_____
_____
_____
_____
_____
_____
_____
_____

What are you hoping to get out of this evaluation/experience?

_____
_____
_____
_____
_____

What are YOUR goals for your child's development over the coming year?

a. _____
b. _____
c. _____

Thank you for your time and effort in completing this lengthy form!!

Steevie Jane Parks, Ph.D.