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Child DEVELOPMENTAL HISTORY Questionnaire

Name of Child: _____ Today's Date: _____
Child's Date of Birth: _____ Child's Age: _____

Directions: This questionnaire is to be filled out by parent(s) or any adult(s) responsible for the patient. Please answer all relevant questions, do not skip any, and try to be as frank and thorough as you can. For any questions that require a "YES" or "NO" answer, please check the appropriate answer, IF YOU DO NOT KNOW, write "UNKNOWN" or "DO NOT REMEMBER". If you need more space, you can write on the back of the last page. Please PRINT or TYPE.

Name(s) of responsible adult(s) completing this form: _____

1) Normal Pregnancy? Yes () No () If mother was ill during pregnancy, state illness, month of pregnancy illness, type of treatment received, and how long condition lasted:

Did you plan to have this child? Yes () No () Do not remember ()

2) Length of pregnancy _____ (months) Length of active labor _____ (hours) Birth weight _____ APGAR scores _____ Was pregnancy: Easy () Difficult () Was infant premature? Yes () No () Type of delivery: (underline one): Spontaneous Forceps Caesarian Was infant born head first? Yes () No ()

Feet First? Yes () No ()

Breech? Yes () No ()

Was it necessary to give infant oxygen? Yes () No ()

If yes, for how long? _____ Did infant require blood transfusions? Yes () No ()

3) Condition of child in first two weeks of life. (Answer "Yes", "No", "Unknown" or "Do Not Remember")

Did baby appear yellow? _____ Did baby have vomiting? _____

Nursing difficulty? _____ Birth Defects? _____

Irritable? _____ Slow in responding? _____

Very high fever? _____ Neurological problems? _____

Blue lips? _____ Difficulty breathing? _____

Convulsions or twitching? _____ Slow in responding? _____

Slow in attaching/bonding? _____ Colicky? _____

4) Later infancy: (Answer “Yes”, “No”, “Unknown” or “Do Not Remember”)
Breast fed? Yes () No () If yes, how long?

Did infant feed well? Yes () No () If not, explain: _____

Any problems with vomiting, diarrhea, constipation, or colic? Which? _____

Was there a normal weight gain? Yes () No () Percentile at pediatrician _____

5) Was there ever any: (If yes, please describe)

Head banging? _____ Thumb sucking? _____ Teeth Grinding? _____ Temper tantrums? _____

6) At what age did child: (Check one)

First Smile:

Less than 1 month _____ 1-2 months _____ 2-3 months _____ 3-4 months _____

4-5 months _____ 5-6 months _____ More than 6 months _____

Weaned from bottle:

Less than 6 months: _____ 6-9 months _____ 9-12 months _____ 12-15 months _____

15-18 months _____ 18-24 months _____ 24-30 months _____ 30-36 months _____

More than 3 years _____

First Teeth:

0-5 months _____ 5-9 months _____ 9-12 months _____ 12-15 months _____

15-18 months _____ 18-21 months _____ 21-24 months _____ 24-27 months _____

27-30 months _____ More than 2 years _____

Stand alone:

5-9 months _____ 9-12 months _____ 12-15 months _____ 15-18 months _____

18-21 months _____ 21-24 months _____ 24-27 months _____ 27-30 months _____

More than 2 years _____

Walk alone:

Less than 12 months _____ 12-15 months _____ 15-18 months _____ 18-21 months _____

21-24 months _____ 24-27 months _____ 27-30 months _____ 30-33 months _____

33-36 months _____ More than 3 years _____ Does not walk alone _____

Speak Words:

Less than 6 months _____ 6-9 months _____ 9-12 months _____ 12-15 months _____

15-18 months _____ 18-24 months _____ 24-30 months _____ 30-36 months _____

More than 3 years _____ Does not speak _____

Speak Sentences:

Never spoke sentences _____ Less than 1 year _____

1- 1 1/2 years _____ 1 1/2-2 years _____ 2—2 1/2 years _____

2 1/2 - 3 years _____ 3-3 1/2 years _____ 3 1/2 -4 years _____

4-4 1/2 years _____ More than 4 1/2 years _____

7) Toilet training --at what age: _____

Trained for bowels:

12-15 months _____ 15-18 months _____ 18-24 months _____ 24-30 months _____

30-36 months _____ More than 3 years _____ Not begun yet _____

Dry during: Day Night

Less than 6 months	_____	_____
6-12 months	_____	_____
12-15 months	_____	_____
15-18 months	_____	_____
18-24 months	_____	_____
24-30 months	_____	_____
30-36 months	_____	_____
More than 3 years	_____	_____

Not begun yet: _____ Not dry during day: _____ Not dry during night: _____

Were there training problems? Yes () No () If yes, specify: _____

8) If adolescent, have there been the following changes or developments, and at what age did they begin? (Answer "Yes", "No", "Unknown" or "Do Not Remember") Voice _____ Pubic Hair _____ Hair on Face _____ Menstruation _____ Breast development _____

9) List below illnesses, injuries, emergency room visits, and operations your child has had. The following are the most common ones (but certainly enter ones that are not mentioned): Underline all experienced: Asthma, eczema, arthritis, diabetes, cancer, anemia, measles, mumps, chickenpox, diphtheria, scarlet fever, polio, cerebral palsy, encephalitis, tuberculosis, heart disease, influenza, pneumonia, migraine headaches, undescended testicles, high or low blood pressure, sinusitis, heart surgery, appendicitis, tonsillectomy, unconsciousness, brain injury, fainting, dizziness, meningitis, broken bones, convulsions, others. Hospitalized? _____ Attending Physician: _____ Injury age: _____

Illness: _____
How long? _____

10) Any physical handicaps, disabilities, or deformities? Yes () No () If yes, please specify: _____

Eyes: Normal? Yes () No () If No, specify: _____

Wears glasses? Yes () No ()

Hearing normal? Yes () No () If No, specify: _____

Teeth: Extractions? Yes () No () Straightened? Yes () No ()

Is child very much overweight? Yes () No () Or underweight? Yes () No ()

Is child very short? Yes () No () Or very tall? Yes () No ()

Approximate weight of child _____ Percentile at pediatrician _____

Approximate height of child _____ Percentile at pediatrician _____

11) List main extracurricular activities your child participates in and approximate average number of hours per hours per week involved. If the activity requires a skill, please check whether the child is below average, average, or above average. Examples of various activities are: climbing, fishing, checkers, dating, swimming, stamp collecting, model airplanes, sewing, football, dancing, musical instruments, reading, TV, etc. .

Activity Hours per Week Skill Level

12) Health of other family members (Parents, Grandparents, Aunts, Uncles, Cousins, Siblings). List any serious physical handicaps, operations or deaths that have occurred to members of the child’s household since the child was born. Do not include common childhood illnesses, colds etc. Examples would be cancer, diabetes, epilepsy, heart disease, bipolar illness, schizophrenia, autism, Tourettes, or ADHD).

Adults Name Relationship Illness

Children Name Relationship Illness

Please make any other comments or additions that you need to make to help me understand your child better.
