CHILD DEVELOPMENTAL AND BEHAVIORAL HISTORY QUESTIONNAIRE

Name of person completing this questionnaire _____ Date completed _____

BASIC IDENTIFYING INFORMATION

Child's name _____ Birthdate _____ Age _____ Gender _____ Hand dominance _____

Address _____ Phone _____

Father's name _____ Age _____ Education_____ Occupation _____

Mother's name_____ Age _____ Education_____ Occupation _____

If parents are divorced, who has custody of the child? _____

Is child adopted? _____ Age when adopted _____ Does the child spend time with biological parents?_____

Please list *first names* of other children living in the child's current home, and indicate if any of these are not the child's biological siblings (e.g., step-siblings, half-siblings).

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Please list first names and ages of any biological siblings who are not currently living with the child:

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Please list names of any adults other than parents who are living in the home at present:

Name_____ Relationship to child_____

Name_____ Relationship to child_____

BASIC MEDICAL INFORMATION

Family doctor_____ Address_____ Phone_____

Recent illnesses_____ Recent injuries_____

List any medications regularly taken (name and dosage)_____

_____

Does the child use hearing aids?_____ Wear glasses?_____ Use adaptive equipment? (specify type) _____

Does your child have any medical conditions, such as asthma, ear infections, diabetes, etc.?_____

_____

Does your child have any history of illness or injury that might affect the brain, such as head injury, concussion, seizures, brain tumor, etc.?_____

_____

Does your child have any history of mental health diagnoses, such as depression, anxiety, ADHD, etc.?_____

_____

Do any immediate family members (parents or siblings) have any of the following conditions? If yes, please circle.

Epilepsy/seizures	Brain Tumor	Schizophrenia	Depression	Bipolar disorder
Anxiety/phobias	Drug/alcohol abuse	Learning disability	ADHD	Mental retardation
Genetic Conditions (e.g., Fragile X)				

PRENATAL/PREGNANCY HISTORY

Mother's age when pregnant with child_____ Did mother receive regular prenatal care?_____

Did mother consume tobacco, alcohol or other non-prescribed drugs during pregnancy?_____ Describe_____

Please describe any complications during pregnancy_____

BIRTH HISTORY

Length of gestation (pregnancy)_____ Birth weight_____ Apgar scores (if known) _____

Describe any complications during the delivery or immediately following_____

Did the child have any known birth defects?_____ Describe_____

EARLY DEVELOPMENT

Any problems with initial development (e.g., feeding problems, failure to thrive, etc.)?_____ Describe_____

Was there any serious illness or injury to the baby during the first year?_____ Describe_____

Please give the age at which the child was able to do the following (if uncertain, give best estimate):

	Age (months/years)		Age (months/years)
Crawl	_____	Speak first words	_____
Stand alone	_____	Put 2 or more words together	_____
Walk	_____	Ride bicycle	_____
Toilet trained	_____	Tie own shoes	_____
Read single words	_____		

Please describe anything you feel was unusual about this child's development_____

_____

FAMILY HISTORY

Were the parents married when the child was born?_____ Are they married to one another at present?_____ Is either remarried?_____

If divorced, how old was the child when the parents divorced?_____ Does the child spend regular time with both parents?_____

Has there been violence in the child's home? _____ Drug/alcohol abuse?_____ Frequent family moves?_____

Has there been any recent family trauma (e.g., injury of parent, house fire, auto accident)?_____ Describe_____

Has the children been subject to abuse or neglect? _____ Describe_____

Any recent change in the family (birth, death, wedding, divorce, etc.)?_____ Describe_____

How well does the child get along with other family members? Describe_____

SCHOOL HISTORY

Current School_____ The experience is (circle one): Positive So-so Negative

Current grade_____ Ever skipped a grade?_____ Ever retained in a grade?_____ Receive special services?_____

Prior schools:

Name/town	Dates or grade attended	The experience was - - (circle one)
_____	_____	Positive So-so Negative
_____	_____	Positive So-so Negative

Subjects the child does particularly well at_____ Does not do well at_____

Did the child have trouble initially learning to read?_____ Write?_____ Do math?_____

Has the child ever been identified as having any type of learning disability?_____ Describe_____

Please describe any particular problems the child has in school, with school work, or with homework _____

If the child is having school problems, please share your ideas about what might be causing the problems_____

GENERAL COMMENTS

Please describe the child's greatest strengths or assets. What is most lovable or endearing? _____

What concerns you the most about the child?_____

Additional comments_____

CHILD PROBLEM CHECKLIST

Please carefully review the following list of problems. If any of them apply to your child ***currently or in the past several months***, please check the level of severity (mild, moderate or severe). *If there are no problems, leave the boxes blank.*

	Mild Problem	Moderate Problem	Severe Problem	Comments
SLEEP				
Falling asleep	❑	❑	❑	
Restless, poor sleep	❑	❑	❑	
Nightmares	❑	❑	❑	
Getting up in morning	❑	❑	❑	
ENERGY/FATIGUE				
Too much energy	❑	❑	❑	
Low energy/stamina	❑	❑	❑	
APPETITE/WEIGHT				
Not eating enough	❑	❑	❑	
Eating too much	❑	❑	❑	
Poor food choices	❑	❑	❑	
Binging/purging	❑	❑	❑	
Weight (over/under)	❑	❑	❑	
BOWELS/BLADDER				
Accidents/soiling	❑	❑	❑	
Bed wetting	❑	❑	❑	
Diarrhea/constipation	❑	❑	❑	
PAIN				
Stomach aches	❑	❑	❑	
Headaches	❑	❑	❑	
Other aches/pains	❑	❑	❑	
HEARING				
Overly sensitive	❑	❑	❑	
Hard of hearing	❑	❑	❑	
VISION				
Poor acuity	❑	❑	❑	
Sensitivity to light	❑	❑	❑	
SENSORY SENSITIVITIES				
Smell	❑	❑	❑	
Touch	❑	❑	❑	
Food textures	❑	❑	❑	
Clothing	❑	❑	❑	
BALANCE/COORDINATION				
Eye-hand coordination	❑	❑	❑	
Balance	❑	❑	❑	
Walking/running	❑	❑	❑	

	Mild Problem	Moderate Problem	Severe Problem	Comments
SPEECH/LANGUAGE				
Thinking of words, names	❑	❑	❑	
Expressing thoughts	❑	❑	❑	
Understanding conversation	❑	❑	❑	
Pronunciation	❑	❑	❑	
ATTENTION/CONCENTRATION				
Staying focused on task	❑	❑	❑	
Easily distracted	❑	❑	❑	
Needing repetition	❑	❑	❑	
Completing tasks/projects	❑	❑	❑	
EXECUTIVE				
Impulsive/disinhibited	❑	❑	❑	
Organizing belongings	❑	❑	❑	
Organizing tasks	❑	❑	❑	
Planning projects	❑	❑	❑	
Procrastinates	❑	❑	❑	
Making decisions	❑	❑	❑	
Dealing with change	❑	❑	❑	
MEMORY				
Recalling old information	❑	❑	❑	
Recalling recent information	❑	❑	❑	
Recalling names	❑	❑	❑	
Forgetfulness	❑	❑	❑	
Loses things	❑	❑	❑	
SCHOOLING				
Reading	❑	❑	❑	
Writing	❑	❑	❑	
Math	❑	❑	❑	
Behavior	❑	❑	❑	
Attendance	❑	❑	❑	
Homework	❑	❑	❑	
WORK (adolescents, if applicable)				
Conflict with supervisors	❑	❑	❑	
Conflict with co-workers	❑	❑	❑	
Productivity, speed	❑	❑	❑	
Stress at or about work	❑	❑	❑	
SOCIAL				
Poor social skills	❑	❑	❑	
Verbal conflict with others	❑	❑	❑	
Aggressive with others	❑	❑	❑	
Choice of friends	❑	❑	❑	
Gullible, easily influenced	❑	❑	❑	
Shy, fearful	❑	❑	❑	
Isolated, lonely	❑	❑	❑	
Bullied/teased	❑	❑	❑	
Making/keeping friends	❑	❑	❑	
Poor boundaries	❑	❑	❑	

	Mild Problem	Moderate Problem	Severe Problem	Comments
DRUG USE (if applicable)				
Alcohol	❑	❑	❑	
Marijuana	❑	❑	❑	
Tobacco	❑	❑	❑	
Other nonprescribed drugs	❑	❑	❑	
EMOTIONAL				
Anger/irritability	❑	❑	❑	
Temper tantrums	❑	❑	❑	
Depression	❑	❑	❑	
Nervousness, worry	❑	❑	❑	
Fears, phobias	❑	❑	❑	
Low self-esteem	❑	❑	❑	
Moody, ups & downs	❑	❑	❑	
Suicidal thoughts	❑	❑	❑	
REPETITIVE BEHAVIORS				
Tics	❑	❑	❑	
Obsessions/compulsions	❑	❑	❑	
Hoarding	❑	❑	❑	
Odd mannerisms/habits	❑	❑	❑	
Gets stuck on things	❑	❑	❑	
Unusual movements (e.g., hand-flapping)	❑	❑	❑	
OTHER BEHAVIORS				
Hallucinations	❑	❑	❑	
Unusual thoughts	❑	❑	❑	
Delusions/paranoia	❑	❑	❑	
Sexual issues	❑	❑	❑	
Self-injury/cutting	❑	❑	❑	
Other	❑	❑	❑	

(Please explain_____)

COMMENTS: Please describe any other problems that are not listed above.

_____

_____

_____

_____

_____

_____

_____

_____

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When complete, please return to:

Neuropsychology Service, P.A.
277 State St., Suite 2A
Bangor, ME 04401