

DEVELOPMENTAL HISTORY QUESTIONNAIRE

DATE _____

NAME OF CHILD/ADOLESCENT _____

QUESTIONNAIRE COMPLETED BY _____ RELATIONSHIP _____

Welcome to R.E.A.D.S. Collaborative. It is important that you complete the attached *Developmental History Questionnaire* and the age appropriate *Supplemental Questionnaire Form* prior to your scheduled visit. The information you provide enables us to service your individual needs. We are grateful for your assistance in this process and share your concern for your child's well being and academic success. Please call us if you are in need of further explanation or assistance.

**I HAVE THE FOLLOWING CONCERNS REGARDING MY CHILD'S EDUCATIONAL,
EMOTIONAL AND/OR SOCIAL WELL BEING;**

1. _____
2. _____
3. _____
4. _____

MY CHILD HAS STRENGTHS AND TALENTS IN THE FOLLOWING AREAS;

1. _____
2. _____
3. _____
4. _____

PREGNANCY HISTORY

MOTHER BEGINS REGULAR PRE-NATAL CARE AT _____ MONTHS. MOTHER'S AGE AT TIME OF DELIVERY IS _____ YEARS.

THIS IS MOTHER'S _____ PREGNANCY (INCLUDE LIVE BIRTHS, STILLBORN AND MISCARRIAGE).

_____ LIVE BIRTHS _____ MISCARRIAGE _____ STILLBORN BIRTH _____ CESAREAN DELIVERIES

PREGNANCY WAS uncomplicated

PREGNANCY WAS complicated

- HIGH BLOOD PRESSURE
- DIABETES
- TOXEMIA
- SERIOUS INJURY OR ACCIDENT
- VAGINAL BLEEDING IN _____ MONTH
- X-RAYS OR ULTRASOUND IN _____ MONTH
- INFECTION (explain) _____
- MOTHER SMOKED CIGARETTES (_____ PER DAY)
- MATERNAL ALCOHOL USE (_____ DAILY)
- MATERNAL DRUG USE
 - PRESCRIPTION _____
 - NON-PRESCRIPTION _____
 - OTHER _____

Physician Comment : _____

BIRTH HISTORY

DATE OF BIRTH _____ MALE FEMALE PLACE OF BIRTH _____

BIRTH WEIGHT _____ LBS. _____ OZ. SINGLE BIRTH MULTIPLE BIRTH _____

- FULL TERM PREGNANCY
- PRE-TERM PREGNANCY _____
- POST-TERM PREGNANCY _____
- CHILD IS ADOPTED
- FOSTER CHILD
- OTHER _____
- LABOR WAS SPONTANEOUS
- LABOR WAS INDUCED

DELIVERY WAS uncomplicated

DELIVERY WAS NORMAL (NVD)

DELIVERY WAS complicated

- DELIVERY WAS BY FORCEPS
- DELIVERY WAS BREECH
- DELIVERY WAS BY CESAREAN SECTION
- RH PROBLEM _____
- CORD AROUND NECK _____
- INFANT JAUNDICE
 - OTHER _____
- INFANT REQUIRES RESUSCITATION

- INFANTS APGAR SCORE IS ____/____
- INFANT RECEIVES STANDARD NURSERY CARE

- I DO NOT KNOW APGAR SCORE
- INFANT PLACED IN NEO-NATAL OR INTENSIVE CARE NURSERY

- INFANT IS BREAST FED
 - TOLERATES WELL
 - DOES NOT TOLERATE WELL _____

- INFANT IS FORMULA FED
 - TOLERATES WELL
 - DOES NOT TOLERATE WELL _____

Physician Comment : _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ TELEPHONE(_____)_____

PHYSICIAN'S ADDRESS: _____

WHEN DID YOUR CHILD LAST SEE A MEDICAL DOCTOR ? _____ REASON: _____

ALLERGY; NONE KNOWN SEASONAL ENVIRONMENTAL FOOD PET/ANIMAL MEDICINES _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS ? (IF YES, PLEASE CHECK AND EXPLAIN BELOW)

- Grid of 21 medical conditions with checkboxes: CHICKEN POX, MEASLES, GERMAN MEASLES, MUMPS, WHOOPING COUGH, SCARLETINA, RHEUMATIC FEVER, HEART MURMUR, CHEST PAIN, ASTHMA, ALLERGY, ARTHRITIS/JOINT REDNESS, HEAD INJURY, CONCUSSION, SEIZURE DISORDER, LOSS OF CONSCIOUSNESS, HEADACHE/MIGRAINE, EYE PROBLEMS/INJURY, EAR INFECTIONS, HEARING LOSS, DIFFICULTY BALANCING, DENTAL PROBLEMS, DIFFICULTY SWALLOWING, DIFFICULTY WITH SPEECH, RECURRING SORE THROAT, STREP/STAPH INFECTION, SLEEP DISORDER, MONONUCLEOSIS, PNEUMONIA, BRONCHITIS, SKIN DISEASES; ECZEMA, ACNE, DIABETES, HEPATITIS, KIDNEY DISEASE OR INJURY, BLOOD DISEASE, STOMACHACHES, CONSTIPATION, FREQUENT DIARRHEA, UNUSUAL WEIGHT GAIN/LOSS, BONE FRACTURES, SCOLIOSIS, LEAD EXPOSURE

PLEASE EXPLAIN: _____

HOSPITALIZATIONS:

DATE: _____
NAME OF HOSPITAL: _____
ADDRESS: _____
TOWN/CITY/STATE: _____
REASON: _____

DATE: _____
NAME OF HOSPITAL: _____
ADDRESS: _____
CITY/TOWN/STATE: _____
REASON: _____

ACCIDENTS (OTHER THAN MINOR CUTS AND BRUISES): _____

EMOTIONAL TRAUMA OR PROBLEM: _____

PSYCHOTHERAPY OR COUNSELING:

DATE: _____
NAME: _____
ADDRESS: _____
TOWN/CITY: _____
TELEPHONE: _____

DATE: _____
NAME: _____
ADDRESS: _____
TOWN/CITY: _____
TELEPHONE: _____

SPECIAL EVALUATIONS, STUDIES OR TESTING (INCLUDES GENETIC ANALYSIS)

TEST DATE: _____
LOCATION: _____
ADMINISTERED BY: _____
REASON: _____
RESULTS: _____

TEST DATE: _____
LOCATION: _____
ADMINISTERED BY: _____
REASON: _____
RESULTS: _____

Physician Comment : _____

CURRENTLY, CHILD TAKES THE FOLLOWING SUPPLEMENTS OR MEDICINES ON A REGULAR BASIS;

PRESCRIPTION

NON-PRESCRIPTION

CHILD HAS TAKEN ANTIBIOTICS IN THE PAST. NO YES,TYPE AND REASON _____

CHILD LAST SAW A DENTIST ON _____, FOR (REASON) _____.

CHILD IMMUNIZATION RECORDS ARE UP TO DATE. YES NO UNSURE; _____
(Physician, please review School Immunization Record)

Physician Comment : _____

GROWTH AND DEVELOPMENT

CHILD SAT FREE AT _____ MONTHS.

CHILD WAS TOILET TRAINED AT _____ MONTHS.

CHILD WALKED ALONE AT _____ MONTHS.

CHILD KNEW COLORS AT _____ YEARS.

CHILD SPOKE SINGLE WORDS AT _____ MONTHS.

CHILD KNEW LETTERS AT _____ YEARS.

CHILD'S DEVELOPMENT WAS; AVERAGE COMPARED TO PEERS SLOWER THAN PEERS MORE ADVANCED THAN PEERS

CHILD'S ACTIVITY LEVEL WAS; AVERAGE COMPARED TO PEERS SLOWER THAN PEERS MORE ACTIVE HYPERACTIVE

CHILD'S ATTENTION SPAN WAS; AVERAGE COMPARED TO PEERS SHORTER THAN PEERS LONGER THAN PEERS

CHILD IS RIGHT HANDED LEFT HANDED AMBIDEXTROUS; _____

SLEEP HISTORY; CHILDHOOD NIGHTMARES NIGHT TERRORS TALKS IN SLEEP SLEEPWALKS

DIFFICULTY FALLING ASLEEP DIFFICULTY STAYING ASLEEP GRINDS TEETH SLEEPS RESTLESS SLEEPS WELL

COMMENTS: _____

CHILD DEVELOPED SECONDARY SEX CHARACTERISTICS AT ____ YEARS. (GIRLS: BREAST DEVELOPMENT; BOYS: PUBIC HAIR)

CHILD HAS BEGUN MENSTRUATION. NO YES; PLEASE PROVIDE ADDITIONAL INFORMATION REQUESTED

DATE OF FIRST MENSTRUAL PERIOD WAS _____. DATE OF LAST MENSTRUAL PERIOD IS _____.

CYCLES ARE REGULAR IRREGULAR

WITH LITTLE OR NO DISCOMFORT OR CRAMPING CRAMPING,BLOATING,DISCOMFORT

CHILD STARTED NURSERY SCHOOL AT _____ YEARS OF AGE.

CHILD STARTED KINDERGARTEN AT _____ YEARS OF AGE.

CHILD STARTED FIRST GRADE AT ____ YEARS OF AGE.

CHILD REPEATED GRADE(S) ____, ____, ____, ____.

CHILD IS CURRENTLY IN GRADE ____.

CHILD; ENJOYS SCHOOL EXPERIENCE DOES NOT LIKE SCHOOL BECAUSE _____
_____.

CHILD HAS HOBBIES OR INTERESTS NO YES; _____

CHILD PARTICIPATES IN SPORTS NO YES; _____

CHILD PARTICIPATES IN SCHOOL ORGANIZATIONS/CLUBS; NO YES; _____

CHILD PARTICIPATES IN COMMUNITY ORGANIZATIONS; NO YES; _____

Physician Comment : _____

SOCIAL HISTORY

CHILD CURRENTLY LIVES AT HOME OTHER (SPECIFY) _____

CHILD RESIDES IN THE CARE OF (PLEASE CHECK APPROPRIATE BOXES BELOW);

- | | | |
|--|--|---|
| <input type="checkbox"/> BIOLOGICAL MOTHER | <input type="checkbox"/> ADOPTIVE FATHER | <input type="checkbox"/> FOSTER FAMILY |
| <input type="checkbox"/> BIOLOGICAL FATHER | <input type="checkbox"/> STEP FATHER | <input type="checkbox"/> RELATIVE _____ |
| <input type="checkbox"/> ADOPTIVE MOTHER | <input type="checkbox"/> STEP MOTHER | <input type="checkbox"/> OTHER _____ |

RESIDENTIAL PROGRAM _____

LANGUAGE SPOKEN AT HOME IS ENGLISH OTHER _____

SIBLINGS NO YES; (PLEASE COMPLETE BELOW)

NAME	DATE OF BIRTH	RESIDENCE	EDUCATION	HEALTH

WHO IS SPENDING MOST TIME WITH CHILD? _____

METHOD OF DISCIPLINE MOST OFTEN USED IS _____

CHILD/ADOLESCENT SMOKES CIGARETTES. NO YES; _____ PPD

CHILD/ADOLESCENT EXPERIMENTS WITH MARIJUANA. NO YES; OCCASIONALLY DAILY WEEKENDS ONLY

CHILD/ADOLESCENT EXPERIMENTS WITH ALCOHOL. NO YES; OCCASIONALLY DAILY WEEKENDS ONLY

CHILD/ADOLESCENT EXPERIMENTS WITH HARD DRUGS. NO YES; OCCASIONALLY DAILY WEEKENDS ONLY
SUBSTANCE OF CHOICE IS _____ UNKNOWN

HAS CHILD/ADOLESCENT BEEN INVOLVED WITH THE POLICE, LEGAL OR CORRECTIONAL AUTHORITIES (INCLUDES TRUANCY)?

NO YES; EXPLAIN _____

IS CHILD/ADOLESCENT CURRENTLY PROHIBITED BY LAW FROM BEING IN THE COMPANY OF MINOR CHILDREN WITHOUT SUPERVISION? NO YES; EXPLAIN _____

Physician Comment : _____

FAMILY MEDICAL HISTORY

MOTHER'S NAME:	FATHER'S NAME:
DATE OF BIRTH: AGE:	DATE OF BIRTH: AGE:
PLACE OF BIRTH:	PLACE OF BIRTH:
EDUCATION:	EDUCATION:
OCCUPATION:	OCCUPATION:
HEALTH:	HEALTH:

GRANDPARENTS	HEALTH	IF DECEASED, CAUSE OF DEATH
MATERNAL GRANDMOTHER		
MATERNAL GRANDFATHER		
PATERNAL GRANDMOTHER		
PATERNAL GRANDFATHER		

IF YOUR CHILD OR RELATIVE HAS ANY OF THE FOLLOWING DISORDERS, PLEASE CHECK THE APPROPRIATE BOX AND IDENTIFY THE RELATIONSHIP OF THAT INDIVIDUAL TO THE CHILD IN THE SPACE PROVIDED.

<input type="checkbox"/> ECZEMA, ASTHMA , HAYFEVER	<input type="checkbox"/> HEART DISEASE
<input type="checkbox"/> ALLERGY TO MEDICINE	<input type="checkbox"/> DIABETES
<input type="checkbox"/> BONE OR JOINT PROBLEMS	<input type="checkbox"/> LUNG DISEASE
<input type="checkbox"/> CANCER	<input type="checkbox"/> THYROID DISEASE OR ABNORMAL BODY SIZE
<input type="checkbox"/> BLOOD DISEASE	<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> BIRTH DEFECTS; INCLUDES MENTAL RETARDATION, AUTISM AND CEREBRAL PALSY	<input type="checkbox"/> SEIZURES, CONVULSIONS OR EPILEPSY
<input type="checkbox"/> TUMORS	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> PSYCHIATRIC DISORDER	<input type="checkbox"/> LEARNING DISABILITY OR SCHOOL PROBLEMS
<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> SUBSTANCE ADDICTION
<input type="checkbox"/> HEARING PROBLEM	<input type="checkbox"/> VISION PROBLEM

PLEASE TAKE A MOMENT TO SHARE ANY ADDITIONAL INFORMATION ABOUT YOUR CHILD/ADOLESCENT THAT YOU FEEL MAY BE HELPFUL IN UNDERSTANDING AND RESPONDING TO THEIR PARTICULAR NEED. YOUR INSIGHT IS EXTREMELY BENEFICIAL.

Physician Comment : _____
