Tarazi Neuropsychology Services LLC

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DEVELOPMENTAL HISTORY QUESTIONNAIRE

Please answer all questions as best you can. If you are unsure about some information, please give a "best guess" estimate.

Today's Date_____ / _____ / _____

Child's Name _____ Child's Date of Birth: _____ / _____ / _____

Child's Sex at Birth (circle one): Male Female
Child's Current Gender (circle one): Male Female Other:_____

Name of person completing questionnaire_____
Relationship to child_____
Address: _____
Phone Number(s) _____
Email: _____

Would you like a copy of the evaluation report sent via email despite potential security concerns? YES_____ NO_____

CONCERNS:
Who referred you for an evaluation? _____

What are the main questions you have for this evaluation?

_____

_____

_____

_____

Does your child have any other problems with behavior and or schoolwork/homework?

_____

_____

_____

What have you been told by doctors, teachers, or others about your child?

_____

_____

_____

Please describe your child's strengths:

_____

_____

Please describe your child's weaknesses:

_____

_____

FAMILY INFORMATION:

Parent/ Guardian 1 name: _____ Age: _____
Highest level of education: _____ occupation: _____
Is guardian: Biological Parent Adoptive parent Foster Parent Other:_____

Parent/ Guardian 2 name: _____ Age: _____
Highest level of education: _____ occupation: _____
Is guardian: Biological Parent Adoptive parent Foster Parent Other:_____

If parent/guardian is not biological parent, what is the highest level of education of biological parent(s)?
_____

Parent/ Guardian 1 phone numbers: Home _____Cell_____ Work _____
Parent/Guardian 2 phone numbers: Home _____Cell_____ Work _____

Are parents/caregivers: married separated divorced not married-together never together widowed

Is this child: biologic? adopted? foster child?

Whom does this child live with at the present time? (include parents, guardians, brothers, sisters, grandparents, friends, etc.)
_____

What language(s) is used at home? _____

If more than one language, what is your child's preferred (stronger) language? _____

FAMILY HISTORY:

Please list mother's pregnancies in chronological order (including miscarriages, stillbirths, etc):

Name	Age	length of pregnancy	birth weight	problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list anybody in the family who is left-handed or 'mixed-handed':_____

Has anybody in the child's BIOLOGICAL family (e.g., siblings, parents, grandparents, aunts, uncles) had any of the following? If so, please explain.:

Person (i.e., relationship to child)

Problems with school/learning (e.g., reading, spelling, math)? _____

Speech/Language problems? _____

Hearing or Visual Impairment? _____

Seizures/convulsions/epilepsy? _____

Hydrocephalus (i.e., too much fluid in the brain)? _____

Other neurological disease or disorder? Describe: _____

Mental Illness (i.e., Depression, Anxiety, Schizophrenia, etc.)? _____

Other emotional/Behavioral problems? _____

Alcoholism? _____

Asperger's, Autism, PDD? _____

Attention problems/ overactivity/ ADHD _____

Mental Retardation/Intellectual Disability? _____

Other medical/developmental problem? _____

Genetic Syndrome? _____

BIRTH HISTORY:

Which pregnancy was this for the biological mother (first, second, third, etc.)? _____

Was this child full-term? (i.e., was he/she born at the expected time?) **Yes No** If No, how many weeks gestation?_____

Age of bio mother at delivery: _____ Age of bio father at delivery: _____

During pregnancy:

Did doctor note any problems? **Yes No** Describe: _____

Was mother on any medication? **Yes No** If yes, what medication & why? _____
Did mother smoke? **Yes No** If yes, amount, frequency, & when? _____
Did mother drink alcoholic beverages? **Yes No** If yes, amount, frequency, & when?_____
Did mother use drugs? **Yes No** If yes, what kind, amount, frequency, & when? _____

What was mother's alcohol, tobacco, and drug use habits prior to learning about the pregnancy?_____
_____

Were there any problems with labor? **Yes No** If yes, describe:
_____
_____

Were there any problems with delivery? **Yes No** If yes, describe:
_____
_____

Were forceps used during delivery? **Yes No**

Was a Caesarean section performed? **Yes No** If yes, why? _____

Were there any birth defects or complications? **Yes No** If yes, describe:
_____
_____

What was this child's birthweight? _____ Apgar scores (if known):_____

How long did he/she stay in the hospital? _____

CHILD'S DEVELOPMENTAL HISTORY:

Were there any special problems in the growth and development of the child during the first few years? **Yes No** If yes, describe:

_____
_____

As an infant:

Were there any feeding/swallowing problems? **Yes No** If yes, describe: _____

Were there any sleeping problems? **Yes No** If yes, describe: _____

Compared to other children, did this child have difficulty learning:
to talk? _____
to understand? _____
gross motor skills (walking, hopping, riding bicycle, etc.)? _____
fine motor skills (fastening buttons, zippers, tying shoelaces, drawing, etc.)? _____
early school-related skills (naming colors, saying alphabet, recognizing coins, etc.)? _____
to sit still? _____
to play with other children? _____
to build with blocks, play with puzzles, draw pictures? _____

Please indicate the age at which your child first demonstrated each behavior (If you are uncertain of the exact age, please indicate whether the skill was achieved within normal expectations *or* delayed in development):

Smiled_____ Rolled over _____
Babbled _____ Sat alone _____
Spoke first word_____ Walked alone _____
Put several words together_____ Dressed self _____

Has this child ever lost developmental skills? **Yes No** (if yes, describe): _____
_____

When was this child toilet trained - for day time? _____ for night time? _____
At what age did this child show a clear hand preference? _____
Which hand does he/she prefer now? _____**Right** _____**Left** _____**Mixed** _____**No Preference**
Does this child prefer to play with _____**older,** _____**younger, or** _____**same-age children**?
Does your child communicate mostly by _____**gestures,** _____**words,** _____ **crying,** _____ **phrases, or** _____ **sentences**
For his/her age, is your child _____ **average,** _____ **underweight, or** _____ **overweight**

CHILD'S MEDICAL HISTORY:

Has child had any serious illness? **Yes No**
what? _____
when? _____
how long? _____

Has child ever been hospitalized? **Yes No**
why? _____
when? _____
how long? _____

Has child ever had any operations? **Yes No**
what? _____
when? _____

Seizures/convulsions? _____ If Yes, at what age? _____
were seizures/convulsions associated with high fever? _____

Does child have asthma? **Yes No** If Yes, how severe? _____
Does child have any allergies? **Yes No** If Yes, to what? _____
Has child had any head injuries? **Yes No** If Yes, what happened? _____
_____
when? _____ was child unconscious? **Yes No** For how long? _____

Does child have vision problems? **Yes** **No** Describe: _____
Does child have hearing problems? **Yes** **No** Describe: _____
Does child have a history of frequent ear infections? **Yes** **No** when?_____ how often?_____
were PE tubes ever placed?_____ if yes, at what age? _____

List medications & dosages child currently takes:

Medicine	**Amount**	**Reason**

Has your child ever been evaluated by Neurology or Developmental Pediatrics? **Yes** **No** If Yes, describe tests (e.g., MRI, EEG) & findings:_____
_____

Has your child ever been evaluated by Genetics? **Yes** **No** If Yes, describe tests (e.g., Fragile X, FISH) & findings:_____

_____

Has this child ever had psychotherapy or counseling or seen a psychiatrist? **Yes** **No** if yes, when? _____
with whom? _____
for what? _____

List any diagnoses (medical, psychiatric, behavioral, school, etc.) your child has been previously given: _____
_____

SCHOOL HISTORY

School Name (include Preschool and K)	**Grade(s) or class placement(s)**	**Dates of Attendance**

Present grade (if not in school, please indicate) _____
Address of current school _____
Contact person at school familiar with your child's work _____
Has child ever repeated a grade? **Yes** **No** If yes, which? _____
Did child have an early intervention screening? **Yes** **No** If Yes, describe: _____
_____
In what grade did school problems become noticeable? _____

Has child been evaluated before? **Yes** **No** If Yes, how many times? _____ when was last evaluation?_____

What specific educational interventions have been provided? (e.g., speech therapy, occupational therapy, physical therapy, etc.)
_____

_____

Does child receive special education services now? **Yes** **No** If Yes, what & how often_____
_____
And what is your child's primary handicapping condition? _____

Are you satisfied with your child's current school placement? _____ If not, why? _____
_____
_____

Please use this space to provide any other information you feel will be helpful to us in evaluating your child.