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NAME: _____ **DOB:** _____

CHILD HEALTH AND DEVELOPMENT QUESTIONNAIRE

PEDIATRICIAN		
Pediatrician's/Practice Name		
Street Address:		
City:	State:	Zip:
Phone Number:	How long has child been a patient with pediatrician?	
If child has been a patient of any other pediatrician/practice, please list below including years when child was a patient:		
Pediatrician's/Practice Name		
Pediatrician's/Practice Name		

CURRENT MEDICAL CONDITIONS: *Please list any medical conditions for which your child currently receives treatment.*

Illness/Condition	Physician's Name/ Treatment Dates	Outcome

ALLERGIES: *Please list any allergies your child has, including treatment information.*

Allergy	Treating Physician	Treatment Protocol

CURRENT MEDICATIONS: *Please list any prescription and over-the-counter medications your child takes.*

Medication	Dosage	Purpose

EARLY ILLNESSES/MEDICAL CONDITIONS AND HOSPITALIZATIONS:
Please list any major illnesses/medical conditions and hospitalizations your child has had.

Illness/Condition	Treatment Dates	Outcome

SPECIAL NEEDS TREATMENT HISTORY: *Please list any evaluations and/or treatment such as psychological evaluation, psychiatric evaluation, speech therapy occupational therapy, special diets, special education service, tutoring that your child has received OR currently receives.*

Treatment Dates	Type of Evaluation/Treatment/Service	Facility Name/Contact Information

FAMILY HISTORY: *Please note ay immediate family member with any of the following:*

	Mother	Father	Brother	Sister	Other Sibling	Other Sibling
Attention Difficulties						
Autism, Aspersers						
Speech Problems						
Depression						
Drug/Alcohol Use/Abuse						
Eating Disorders						
Excessive Worry						
Hyperactivity						
Learning Difficulties						
Legal Problems						
Kept back in school						
Oppositional/Defiant						
Separation Problems						
Suicidal Behavior						
Tobacco Use						

FAMILY MEDICAL/PSYCHIATRIC HISTORY: *Please list any extended family member with a history of medical/emotional illnesses including chronic physical conditions, depression, alcohol and/or drug problems, eating disorders, medical and/or psychiatric hospitalizations.*

Name/Gender	Relationship to Child	Condition & Treatment (if known)

PRENATAL/BIRTH HISTORY

Mother's age at time of birth:	Father's age at time of birth:
Number of prior pregnancies:	Was this pregnancy planned?:
Length of Pregnancy (in months):	

MATERNAL ILLNESSES/COMPLICATIONS: *Please list any illness/complications experienced during pregnancy.*

Trimester	Illness/Complication	Course of Treatment/Outcome

MEDICATIONS: *Please list any/all prescription and over-the-counter medications taken during pregnancy.*

Medication	Dosage	Purpose

SUBSTANCE USE: *Please list what, if any of the following substances were used during the time mother was pregnant.*

MOTHER			FATHER		
Substance	Amount Used	Frequency Used	Substance	Amount Used	Frequency Used
Cigarettes			Cigarettes		
Alcohol			Alcohol		
Drug/Type			Drug/Type		
Drug/Type			Drug/Type		

LABOR AND DELIVERY:

Length of time in labor:	Was delivery: ☐ Vaginal birth ☐ Instrument assisted birth ☐ Caesarian birth ☐ Breech birth
What medications, if any, were used during labor and delivery?	
APGAR score, if known:	
Baby's condition at birth:	
Mother's condition at birth:	
If baby stayed in special or intensive care unit following delivery, please describe:	
If mother stayed in special or intensive care unit following delivery, please describe:	

DEVELOPMENTAL HISTORY DURING THE FIRST YEAR: *Please describe the following:*

Was baby breastfed or bottle fed?	Eating patterns:
Temperament	Sleeping patterns
Medical conditions/Illnesses:	
Was there anything significant about baby's first year? If, so please describe.	

DEVELOPMENTAL MILESTONES: *At what age were the following accomplished. Please note anything of significance.*

Skill	Age Accomplished/Anything Significant	Skill	Age Accomplished/Anything Significant
Rolled over		Hold crayon/scribble	
Crawled		Hold pencil/write	
First steps		First words	
Walked alone		2-3 word sentences	
Ran well		Full sentences	
Urine for day		Bowels for day	
Urine for night		Bowels for night	

How would you assess your child's overall rate of development: ☐ Slow ☐ Normal ☐ Fast

DAY CARE/PRESCHOOL HISTORY:

Has child been in day care? ☐ Yes ☐ No If yes, from what age?
Was child in day care center or private home?
Describe day care environment:
What hours/days was child in day care?
Were there any separation issues? ☐ Yes ☐ No If yes, please describe.
Has child been in preschool? ☐ Yes ☐ No If yes, from what age?
What was the name of the preschool?
What hours/days was child in preschool?
Were there any separation issues? ☐ Yes ☐ No If yes, please describe.

EDUCATIONAL HISTORY:

At what age did child begin school?
Were there any separation issues when child began school? ☐ Yes ☐ No If yes, please describe.
What was child's attitude toward starting school?
Has child's attitude toward school changed? ☐ Yes ☐ No If yes, please explain.
Has child been retained/held back in a grade(s)? ☐ Yes ☐ No If yes, please explain.

Does child receive any special education services? ☐ Yes ☐ No If yes, please describe types of services, at what grade services began and any changes in services. Please us the back of this page, if necessary.

SOCIAL BEHAVIOR: *Please answer the following and explain any question to which you answer "no".*

Social Activity	Yes	No	Explanation
Does child play cooperatively with peers?			
Does child play independently?			
Does child have special friend or group of friends?			
Has there been a change in child's choice of friends?			
Does child have any problem separating from major caretakers?			
Does child have contact with extended family members?			

What are child's favorite activities?

Does child enjoy age appropriate activities?

In what, if any, extra-curricular activities does child participate?

Does child play sports? ☐ Yes ☐ No If yes, please describe.

PERSONALITY:

Below, please mark all traits that apply to child now:

☐ Sad	☐ Happy	☐ Leader	☐ Follower	☐ Moody	☐ Friendly
☐ Quiet	☐ Overactive	☐ Independent	☐ Dependent	☐ Sensitive	☐ Affectionate
☐ Fearful	☐ Cooperative	☐ Tantrums	☐ Lethargic	☐ Sleep Problems	☐ Oppositional
☐ Even-tempered	☐ Loner	☐ Social	☐ Anxious	☐ Compulsive	☐ Forgetful

TELEVISION: *Please describe amount and type of television shows child watches during week:*

Day of Week	Amount	Types of Shows/Titles
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

COMPUTER: *Please describe amount of time child spends on computer during week and activities in which child engages:*

Day of Week	Amount	Activities/Games/Internet Websites/Surfing
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

LIFE CHANGING EVENTS: *Please answer the following and explain any question to which you answer "yes".*

Has child experienced/been exposed to any of the following events/situations:

Event	Yes	No	Age	Explanation
Death				
Separation/Divorce				
Violent Behavior				
Abuse				
Natural Disasters				
Substance Abuse				
Pornography				
Other				

LEGAL:

Has child been suspected or accused of any illegal activities? □ Yes □ No If yes, please explain.

Has child been accused or suspected of any sexual offenses? □ Yes □ No If yes, please explain.

Has child been adjudicated in a court of law? □ Yes □ No If yes, please explain.

AGGRESSION TOWARD SELF AND OTHERS:

Has child ever expressed thoughts of suicide or harming self? □ Yes □ No If yes, please explain.

Has child ever made any suicide attempts? □ Yes □ No If yes, please explain.

Has child ever deliberately hurt self? □ Yes □ No If yes, please explain.

Has child ever deliberately hurt someone else? □ Yes □ No If yes, please explain.

Has child ever deliberately hurt animals? □ Yes □ No If yes, please explain.

Name of Minor Child: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian:_____

Relationship to Child: _____

Date; _____