Kristin Rose, PsyD.
202 W. Sandy Lake Rd.
Suite 105
Coppell, TX 75019
972-999-6490
DrRose@RoseTherapyCenter.com

Developmental Background Questionnaire:

This is a detailed questionnaire that will help me greatly in learning about and understanding your child. Please answers the question the best you can and I will answer any questions you have. If possible, it would be helpful for both parents to fill out the questionnaire together.

Demographic Information:

Child's name: ______________________________ Date of Birth: ____________________
Name(s) of person(s) completing this form: ______________________________________
Date: __________

Information about Parents:

Mother's Name: _______________________ Father's Name: ____________________
DOB: __________ DOB: __________
Highest level of education: _______________ Highest level of education: ___________
Occupation: ___________________________ Occupation: _______________________

For Parents who are divorced and remarried:

Step-parent's Name: _____________________ Step-parent's Name: ________________
DOB: __________ DOB: __________
Highest level of education: ________________ Highest level of education: __________
Occupation: ____________________________ Occupation:______________________

What arrangements, if any, are there for visitation or shared custody?

List all people living in the household:

Name	Relationship to Child	Age

List all brothers, sisters or other significant people living outside the household:

Name	Relationship to Child	Age

Recent family stressors (deaths, births, moves, job loss, etc.):

Dominant language spoken in the home: _______________________
Other languages spoken in the home: _________________________

Name of pediatrician: __________________________________
Name of other significant health care providers: _________________________________

Who referred you to Rose Assessment & Therapy Center? __________________________________

Presenting Problem:

Briefly describe your child's current difficulties:

How long has this problem been of concern to you?

When was this problem first noticed?

Has your child received evaluation or treatment for the current problem or similar problems? If yes, please list any therapists, counselors or agencies who have worked with your child.
____
____
____

Is your child being treated for a medical illness? ☐ Yes ☐ No
If yes, for what condition is the child being treated?

Is your child on any medications at this time? ☐ Yes ☐ No
If yes, please fill out the chart below:

Medication	Dosage	Reason for medicine

Pregnancy and Birth History:

Is your child: □ biological child □ adopted child □ foster child □ other: ________________________

Mother's age at birth? ________ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used:

____

Pregnancy lasted ______________weeks / months

Child's birth weight: ______pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No

If No, explain why:____

____

Were there any problems during the pregnancy with your child? □ Yes □ No
If yes, please describe

Was your child exposed to cigarette smoke in utero? □ Yes □ No
Details:

Was your child exposed to any other problematic substances in utero (e.g. drugs, alcohol, X-rays, chemicals, etc)? □ Yes □ No
Details:

Was your child exposed to any infectious diseases in utero?□ Yes □ No
Details:

How long was labor?

Was a c-section performed?

Were there any complications associated with the delivery? (e.g. Umbilical cord around neck, lack of oxygen, meconium staining, jaundice, etc.)

Was Neonatal care needed? □ Yes □ No
If yes, what kind of care and how long was it needed?

□ NICU
□ Special Care Nursery
□ Other

Was there anything else unusual about pregnancy or birth?

Infancy:

Were there any birth defects or complications? ☐ Yes ☐ No
If yes, please describe:

Were there any feeding problems? ☐ Yes ☐ No
If yes, please describe:

Were there any sleeping problems? ☐ Yes ☐ No
If yes, please describe:

Describe your child as an infant (quiet, alert, fussy, etc.)

Did your child like to be held as an infant? ☐ Yes ☐ No

Did your child grow normally? ☐ Yes ☐ No

First Years / Developmental History:

Did your child exhibit any of the following behaviors during the child's first years? Place a check next to each one that he or she showed:

- ☐ Did not enjoy cuddling
- ☐ Was not calmed by being held
- ☐ Was colicky
- ☐ Was excessively restless
- ☐ Had poor sleep patterns
- ☐ Banged head frequently (describe)
- ☐ Had gross-motor problems
- ☐ Did not babble
- ☐ Did not speak
- ☐ Had excessive fears
- ☐ Ignored toys
- ☐ Was attached to an unusual object (specify)
- ☐ Was constantly into everything
- ☐ Had an excessive number of accidents
- ☐ Was exposed to lead
- ☐ Had fine-motor problems
- ☐ Was not interested in other children
- ☐ Did not smile socially
- ☐ Was unaware of painful bumps or falls
- ☐ Had peculiar pattern of speech
- ☐ Preferred to play alone
- ☐ Had poor eye contact
- ☐ Was insensitive to cold or pain
- ☐ Did not wave bye-bye

Motor Development:

Age crawled alone____ Walked alone _____

Was your child slow to develop motor skills or awkward compared to siblings, friends (e.g. Running, skipping, climbing, biking, playing ball?)
____
____

Handedness: Right____ Left____ Both_____

Family history of left handedness? (List relatives) _______________________

Was Physical Therapy ever necessary? (when?) ____________________

Was Occupational Therapy ever necessary? (when?) ____________________

Speech/Language Development:

Age spoke first word ______ put 2-3 words together _______

Speech delays/problems (e.g. Stutters, difficult to understand)?___________
Oral-motor problems (e.g. Late drooling, poor sucking, poor chewing)? _____________
Was speech/language therapy ever necessary? _________________________________

Was child slow to learn the alphabet? _______ name colors? _______ count? ________

Were their any other special problems in the growth and development of your child during the first few years? □ Yes □ No
If yes, Please describe:
____

Language and Speech Checklist:

- □ Speaks in shorter sentences than expected for age
- □ Does not know names of common objects
- □ Has difficulty recalling familiar words
- □ Substitutes vague words (e.g. "thing") for specific words
- □ Responds better to gestures than to words
- □ Does not make appropriate gestures to communicate
- □ Uses gestures instead of words to express ideas
- □ Has difficulty making speech understood
- □ Speaks very slowly
- □ Speaks too fast
- □ Is often hoarse
- □ Has unusually loud speech
- □ Has unusually soft speech
- □ Makes sound but no words
- □ Mixes up the order of events
- □ Seems uninterested in communicating
- □ Prefers to speak to adults only
- □ Prefers to speak to children only
- □ Prefers to speak to family members only
- □ Speaks in monotone, sing song, or exaggerated manner

Medical History:
Place a check next to any illness of conditions that your child has had. When your check an item, also note the approximate age of the child when he or she had the illness or condition:

	Age		Age
□ Measles	___	□ Frequent headaches	___
□ Head Injuries	___	□ Difficulty concentrating	___
□ Mumps	___	□ Memory problems	___
□ Chicken pox	___	□ Extreme tiredness	___
□ Whooping cough	___	□ Rheumatic fever	___
□ Diphtheria	___	□ Epilepsy	___
□ Polio	___	□ Tuberculosis	___
□ Scarlet fever	___	□ Bone or joint disease	___
□ Meningitis	___	□ Gonorrhea or syphilis	___
□ Encephalitis	___	□ Anemia	___
□ High fever	___	□ Jaundice	___
□ Convulsions	___	□ Hepatitis	___
□ Allergies (please list):__________	___	□ Cancer (list type): __________	___
□ Injuries to head	___	□ Diabetes	___
□ Seizures	___	□ High blood pressure	___
□ Broken bones	___	□ Heart disease	___
□ Hearing problems	___	□ Asthma	___
□ Ear infections (tubes needed?)	___	□ Bleeding problems	___
□ Sleeping problems	___	□ Eczema or hives	___

☐ Fainting spells ___
☐ Loss of consciousness ___
☐ Paralysis ___
☐ Dizziness ___
☐ Suicide attempts ___
☐ Sleeping problems ___
☐ HIV ___
☐ AIDS ___

Does your child have any disabilities?

Has your child had any serious illnesses?

Has your child been hospitalized?

Has your child had any operations?

Has your child had any accidents?

Are your child's immunizations up to date?

Child's height? ____________ Child's weight? ____________
Do you have concerns regarding your child's weight or eating habits?_______________
____
____

Date of any vision evaluation:__________________ Results: ______________________
Date of any hearing evaluation:_________________ Results: ______________________

Family Medical History:

Place a check next to any illness or conditions that any member of the immediate family has had. When you check an item, please note the family member's relationship to the child.

	Relationship to Child
☐ Academic problem or Learning Disability	___________________________________
☐ Alcoholism	___________________________________
☐ Cancer	___________________________________
☐ Depression	___________________________________
☐ Developmental problem or Mental Retardation	___________________________________
☐ Diabetes	___________________________________
☐ Drug problem	___________________________________
☐ Emotional problem	___________________________________
☐ Epilepsy	___________________________________
☐ Autism/ Asperger's	___________________________________
☐ Anxiety	___________________________________
☐ Heart trouble	___________________________________
☐ Neurological disease	___________________________________
☐ Suicide attempt	___________________________________
☐ Other problem (please list)	___________________________________

Educational Checklist:

☐ Has difficulty with reading
☐ Has difficulty with arithmetic
☐ Has difficulty with spelling
☐ Has difficulty with handwriting
☐ Has difficulty with other subjects (please list)
____
____
☐ Has difficulty paying attention in class
☐ Has difficulty sitting still in class
☐ Has difficulty waiting turn in school
☐ Has difficulty taking notes in class
☐ Has difficulty respecting others' rights
☐ Has difficulty remembering things
☐ Forgets homework
☐ Has difficulty getting along with teacher
☐ Has difficulty getting along with other children
☐ Dislikes school
☐ Resists going to school
☐ Refuses to do homework

Educational History (Please write in name of school and approximate dates of attendance)

Preschool	Dates:________________________________
Kindergarten	Dates:________________________________
Elementary	Dates:________________________________
	Dates:________________________________
Middle School	Dates:________________________________
	Dates:________________________________
High School	Dates:________________________________
	Dates:________________________________

What is his or her current grade? ____________________
How are your child's grades or marks? _____________________

Is your child in any special education classes? ☐ Yes ☐ No
If yes, what type of class? ____

Has your child been held back in a grade? ☐ Yes ☐ No
If yes, what grade and why? ____

Has your child ever received special tutoring or therapy in school? ☐ Yes ☐ No
If yes, please describe: ____

Has your child ever received special tutoring or therapy outside of school? ☐ Yes ☐ No
If yes, please describe: ____

Has your child's school performance recently declined? ☐ Yes ☐ No
If yes, please describe: ____

Has your child missed a lot of school? ☐ Yes ☐ No
If yes, please indicate reasons: ____

Does your child attend day care after school? ___Where?_________________ How many hours a day?

Social and Behavioral Checklist:

Place a check next to any behavior or problem that your child *currently* exhibits:

 Has difficulty with hearing
 Has difficulty with vision
 Has difficulty with coordination
 Has difficulty with balance
 Has difficulty making friends
 Has difficulty keeping friends
 Refuses to share
 Prefers to be alone
 Does not get along well with brothers/sisters
 Fights verbally with adults
 Yells and calls children names
 Shows wide mood swings
 Is aggressive (describe) _______________
 Is withdrawn (describe) _______________
 Is shy or timid
 Clings to others
 Tires easily, has little energy
 Is more interested in things (objects) than people
 Engages in behavior that could be dangerous to self or others (describe) ____________
 Breaks objects deliberately
 Lies (describe) _______________
 Steals (describe) ______________
 Injures self often accidentally
 Injures self on purpose
 Runs away
 Has low self-esteem
 Blames others for his or her troubles
 Is argumentative
 Does not get along well with other children
 Fights verbally with other children
 Fights physically with other children
 Does not show feelings
 Has frequent crying spells
 Has unusual or special fears, habits, or mannerisms (describe) _______________
 Wets bed
 Sleepwalks
 Sucks thumb
 Bites nails
 Has frequent temper tantrums
 Has trouble sleeping (describe) ________________
 Rocks back and forth
 Bangs head
 Snores while sleeping
 Eats poorly
 Is stubborn
 Has poor bowel control (soils self)
 Is much too active
 Is fidgety
 Is easily distracted
 Takes unnecessary risks
 Gets hurt frequently
 Has too many accidents
 Doesn’t learn from experience
 Feels that he or she is bad
 Is slow to learn
 Moves slowly
 Stares into space for long periods
 Engages in repetitive behavior (e.g. Hand flapping, wheel spinning) _____________
 Does not understand other people’s feelings
 Has difficulty following directions
 Gives up easily
 Complains of aches or pains
 Is disobedient
 Has tics or twitches
 Constantly seeks attention
 Has periods of confusion or disorientation
 Is restless
 Is jealous (describe) ______________
 Is extremely selfish
 Feels hopeless
 Is nervous or anxious
 Is immature
 Is easily frustrated
 Has difficulty learning when there are distractors
 Is suspicious of other people
 Requires constant supervision
 Has difficulty resisting peer pressure
 Shows anger easily
 Has difficulty accepting criticism
 Feels sad or unhappy often
 Talks about wanting to die
 Has poor attention span
 Has poor memory
 Sets fires
 Is afraid of new situations
 Has trouble making plans
 Eats inedible objects
 Is not toilet trained
 Uses illegal drugs (describe) ________________
 Drinks alcohol
 Shows sexually provocative behavior
 Has extreme fear of bathroom or bathing
 Has anxiety when separated from parents
 Has extreme anxiety about going to school
 Has fear of bedtime
 Is wary of any physical contacts with adults in general
 Refuses to sleep alone
 Refuses to go to bed
 Has loss of bladder control

- Is disorganized
- Is clumsy
- Is unusually talkative
- Is forgetful
- Has blank spells
- Daydreams too much
- Worries a lot
- Is impulsive
- Is fearful of strangers
- (in cases of divorce) Is fearful of visiting a parent or caregiver
- Overeats
- Is very eager to please others
- Has compulsion about cleanliness – wanting to wash or feeling dirty all the time
- Other Problems (describe) _________________

Child's Activities:

What does your child like to do for fun?

List any after school activities that your child participates in:
1.
2.
3.
4.
5.

Does your child have any special areas of talent?

What is your child's favorite thing to do with free time?

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.)____

____

How does your child respond to discipline?____

____

List any responsibilities your child has at home: ______________________________________

____

Does your child do these regularly? __Yes __ No

Does your child need frequent reminders? __Yes __No

Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM

Does child sleep well? __Yes __ No

How much time does your child typically spend on electronic media?

____

Watching TV: _____hrs/day; Playing video/computer games: _____hrs/day; Other:______________ hrs/day

What do you hope to learn from the present evaluation?

Please indicate any daily routines that you and your child have (i.e. evening routine):

Has your child ever been in trouble with the law?

What activities do you and your child enjoy together?

Does your child ask religious/spiritual questions? How have you handled these questions?

List three of your child's strengths

List your child's greatest weakness

Thank you for taking the time to fill out this questionnaire.