

## Developmental Questionnaire – Initial Intake

This is a detailed questionnaire with questions that may be difficult to answer because they deal with events in a period that has often been almost forgotten. However, it will help us greatly in this diagnostic study if you try to answer as fully as possible. We will review your answers with you to expand further on any material if you wish. If possible, it would be helpful for both parents to fill out the questionnaire together.

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?

Siblings' Names

DOB

Full/half/step-sib?

Where live if not at home

Names, ages, and relationship of others to whom child is especially close:

**In cases of adoption**

How was the decision to adopt made?

How old was your child when s/he arrived in your home?

How old was your child when the adoption was finalized?

What information were you given about the biological parents and your child's early history?

What was the reaction of your extended family to the adoption?

**Pregnancy**

Was your child planned?

Duration of the pregnancy: \_\_\_\_\_ weeks

**Regarding Mother of child (MOC)**

During the pregnancy:	Yes	No		Yes	No
Did MOC take any medications?	___	___	Did MOC smoke cigarettes?	___	___
Did MOC drink alcohol?	___	___	Did MOC use drugs?	___	___
Did MOC have X-rays?	___		Any medical problems?		___
Any accidents or falls?	___		Was MOC hospitalized?		___
Any problematic anxiety or moodiness?			Any trauma or losses?		___

Please describe in detail any items you checked "yes":

Did MOC feel that the living situation or events in the home were comfortable during the pregnancy?  
Describe:

What were the mother's and father's attitudes and feelings about the pregnancy?

**Delivery and nursery stay**

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ Apgars: @ 1 min. \_\_\_ 5 min. \_\_\_  
Length of labor: \_\_\_\_\_ hours Length of stay: Baby: \_\_\_\_\_ Mother: \_\_\_\_\_

Was the delivery aided by any instruments or special procedures (e.g., C-section, induced labor, forceps)?

Did the baby have any problems after the delivery that needed medical attention (e.g., trouble breathing, jaundice, seizures, paralysis)? Describe:

Did MOC have any problems during or after delivery that needed medical attention? Describe:

Did MOC suffer from post-partum depression? Describe:

Was the father present during the delivery?

What was the father's attitude towards the birth?

### Infancy and early childhood

Was the baby breast-fed? \_\_\_\_\_ Bottle-fed? \_\_\_\_\_ Or both? \_\_\_\_\_

a) If combined feeding, at what age was transfer from breast to bottle made? \_\_\_\_\_ months

b) If bottle-fed, were there difficulties in finding a suitable formula? Describe:

c) If breast-fed (partially or completely), did MOC experience any difficulty with: scanty milk supply, painful nursing, cracked or inverted nipples, etc. Describe:

d) What was baby's response to nursing? Active \_\_\_\_ Eager \_\_\_\_ Had to be encouraged \_\_\_\_

e) Did baby mold to MOC or stiffen and arch away?

f) What were MOC's feelings about the nursing experience? Describe:

g) Which type of feeding was used? Demand \_\_\_\_ Time schedule \_\_\_\_

h) Were there any concerns about baby's weight gain?

When baby vomited, was s/he apt to bring up his food in small amounts or large quantities and with force? Describe:

During early childhood, did your child have any major problems in eating, e.g., chewing, swallowing, choking, refusing to eat, trouble with certain textures? How were these handled?

Were there times when baby had frequent spells of colic, constipation, or diarrhea? At what ages? How was it handled?

What attitude or mood did baby seem to express most of the time (e.g., happy, smiling, laughing, cuddly, whiney, fussy, seemed in pain, sad, "old," hard to engage)? Describe:

Generally babies vary in regard to the amount of activity they show. Which of the following do you think most nearly describes your baby during the first months of life?

\_\_\_ Showed a great deal of activity, such as squirming, wiggling, kicking, and otherwise moving about so that it caused concern or difficulty, or

\_\_\_ Showed very little physical activity, not even showing any increase in movement, interest or response when hungry or played with, or

\_\_\_ Showed vigorous activity when awake and when played with but was equally often observed playing quietly and generally relaxed.

Who assisted MOC in the care and responsibility of baby during infancy? How much assistance? When?

During baby's first year was there anything (even if it had nothing to do with the baby) that caused unhappiness or anxiety in the family or placed the mother or father under special strain? Describe:

When did baby cut his/her first tooth? \_\_\_ months. Did cutting teeth cause any special difficulty, such as excessive crying, loss of weight, fretfulness, etc.?

Where did baby sleep? \_\_\_ alone in a room \_\_\_ in bed with parent(s) \_\_\_ in parents' room in a crib or bassinet . At what age did baby sleep alone in his/her own room or in a room with a sibling? \_\_\_ months. When did baby begin to sleep through the night? \_\_\_ months

Each child has his/her own sleeping pattern. Describe your child's habits, such as, thumbsucking, rocking, requiring a special object (e.g., blanket, toy):

Describe bedtime routines, if any, that were used:

Were there any periods your child habitually awoke crying or had to be held or rocked to fall asleep? At what age? What else would soothe or quiet your child? Describe.

What is your child's current sleep arrangement?

## Developmental milestones

As best you can remember, designate the age at which your child:

Age (months)

- Establish eye contact
- Smile responsively
- Recognize parents
- Hold head erect
- Roll over
- Sit alone
- Babble
- Belly crawl
- Crawl
- Show fear of strangers
- Drink from a cup
- Pull to a stand
- Stand alone
- Walk with support
- Walk alone

Age (months)

- Play pat-a-cake
- Speak first words
- Use 2-word sentences
- Feed self (spoon)
- Bowel trained
- Dry in daytime
- Dry at night
- Scribbled
- Run well
- Ride a tricycle
- Hop on one foot
- Dress self totally
- Ride a two-wheeled bike
- Tie shoes
- Skip

Did your child have difficulties in separating from you when left with others? How did s/he respond when you returned?

Did your child have any delays or difficulties in motor coordination? If so, describe and give ages:

Did your child have any delays or difficulties in speech? If so, describe and give ages:

How old was your child when toilet training was started? \_\_\_\_\_

a) What methods were used to establish bowel and bladder control? (e.g., placed on a toilet seat; how frequently; how long s/he was left there; what was done if successful; what was done if unsuccessful; whether enemas or suppositories were used)

b) Was training made difficult for any physical reasons, such as constipation, diarrhea, etc.?

c) What were your child's reactions and attitudes toward toilet training? Any crying or struggles?

c) Once control was established, were there any relapses? If so, under what circumstances and at what ages?

d) Does your child have any toilet accidents at this time? Describe:

Problems and concerns

If applicable, what were your and your child's reactions to:

Thumb-sucking:

Masturbation:

Nail-biting:

Have any of these areas been of concern to you? (Check those that apply and star those of current concern)

- |   |   |
|---|---|
| <input type="checkbox"/> Overly dependent                             | <input type="checkbox"/> Shy                                      |
| <input type="checkbox"/> Unusual fears or phobias                     | <input type="checkbox"/> Overly anxious                           |
| <input type="checkbox"/> Restless, trouble sitting still              | <input type="checkbox"/> Awkward, clumsy                          |
| <input type="checkbox"/> Difficulty paying attention                  | <input type="checkbox"/> Impulsive                                |
| <input type="checkbox"/> Upset with change                            | <input type="checkbox"/> Restricted, repetitive motor mannerisms  |
| <input type="checkbox"/> Restricted, repetitive interests             | <input type="checkbox"/> Lack of make-believe play                |
| <input type="checkbox"/> Lack of social skills                        | <input type="checkbox"/> Idiosyncratic way of speaking            |
| <input type="checkbox"/> Avoidance of certain textures                | <input type="checkbox"/> Trouble with balance                     |
| <input type="checkbox"/> Fear of movement (spinning, swinging)        | <input type="checkbox"/> Overly sensitive to sounds               |
| <input type="checkbox"/> Difficulty distinguishing left/right         | <input type="checkbox"/> Reversal of letters                      |
| <input type="checkbox"/> Difficulty with spelling & reading           | <input type="checkbox"/> Difficulty with math                     |
| <input type="checkbox"/> Difficulty with writing or coloring          | <input type="checkbox"/> Difficulty manipulating small objects    |
| <input type="checkbox"/> Difficulty understanding what is said        | <input type="checkbox"/> Difficulty following directions          |
| <input type="checkbox"/> Difficulty expressing what s/he wants to say | <input type="checkbox"/> Cruelty to animals                       |
| <input type="checkbox"/> Fire-setting                                 | <input type="checkbox"/> Oppositional, defiant behaviors          |
| <input type="checkbox"/> Bullying, threatening others                 | <input type="checkbox"/> Getting into fights                      |
| <input type="checkbox"/> Stealing                                     | <input type="checkbox"/> Lying                                    |
| <input type="checkbox"/> Destroying property                          | <input type="checkbox"/> Running away from home                   |
| <input type="checkbox"/> Often angry and resentful                    | <input type="checkbox"/> Often blaming of others or circumstances |
| <input type="checkbox"/> Lost in fantasy, daydreaming                 | <input type="checkbox"/> Preoccupation with violence              |
| <input type="checkbox"/> Drug use                                     | <input type="checkbox"/> Sexual acting out                        |
| <input type="checkbox"/> Nightmares                                   | <input type="checkbox"/> Depression                               |
| <input type="checkbox"/> Self-injurious behavior                      | <input type="checkbox"/> Eating disorder                          |
| <input type="checkbox"/> Other _____                                  | <input type="checkbox"/> Other _____                              |

For items checked, please describe in more detail (when began, duration, what was done, what helped):

Did your child have any frightening experiences? Describe:

Describe your child's strengths with regards to abilities, behaviors, etc.:

## Discipline

What methods (e.g., spanking, time-outs, ignoring, withholding of privileges, withholding of approval and affection) did you use in disciplining your child and how did s/he respond--  
During preschool years?

During elementary school years?

During middle school years?

During high school years?

What were major areas that required discipline?

Who usually applied the discipline?

What were major differences, if any, between the parents in their methods of parenting and discipline?

What were major differences between the parents and their relatives in methods of parenting and discipline?

## Attachment

During early years of the child's life, was either parent frequently away or out of the home?

During early years of the child's life, estimate what percent of time spent on parenting was spent by:  
\_\_\_\_% Mother \_\_\_\_% Father \_\_\_\_% Together \_\_\_\_% Other person \_\_\_\_\_

Does the child have a closer attachment to one parent than the other? If so, describe how this is shown.  
Were there any changes in his/her attachments? If so, describe and tell when they occurred:

Did the child strongly attach to any other people? Describe when and whom:

Does your child prefer playing with children who are \_\_\_\_ his/her own age \_\_\_\_ older \_\_\_\_ younger  
\_\_\_\_ with one or two friends \_\_\_\_ many friends?

Has your child ever had difficulties in making and keeping friendships? Describe:

Did your child ever lose anyone with whom s/he was close?

How would you describe your child's personality? (circle those that apply) Happy/sad, optimistic/pessimistic, outgoing/introverted, calm/highstrung, flexible/stubborn, leader/follower, underachiever/overachiever, lackadaisical/perfectionist.

### Siblings

How was your child prepared for the birth of his/her siblings?

How did s/he respond to the birth of siblings?

Does s/he show any marked preferences or dislikes for his/her siblings? Describe how these are expressed.

### Education

Child's academic strengths:

Child's academic weaknesses:

Behavior problems at school:

Extracurricular activities:

Grades: \_\_\_ above average \_\_\_ average \_\_\_ below average Ability: \_\_\_ above average \_\_\_ average \_\_\_ below average Attendance: \_\_\_ usually present \_\_\_ often excused absences \_\_\_ truant

Relations with peers: \_\_\_excellent \_\_\_usually gets along \_\_\_ problems\_\_\_\_\_

Relations with teachers: \_\_\_excellent \_\_\_ usually gets along \_\_\_problems\_\_\_\_\_

Do you feel that schools have adequately dealt with your child's problems? Explain:

Has your child received any special help in the schools (tutoring, special ed, therapy, etc.)? Describe when, whom, what:

Has your child repeated or skipped any grades?

## Health

List major illnesses that your child has had.

Illness	Age	Treatment given (incl. Surgery)	Reactions/after effects
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Does your child have any physical disabilities? Describe:

Has your child ever experienced anesthesia?

What has your child's attitude and reaction been towards doctors and dentists?

Has your child ever had an accident causing physical harm? Describe:

Is your child currently on any medication? What kind? For what? Who prescribed?

Was the child prepared for menstruation (girls) or nocturnal emission (boys)? At what age? Describe child's response to onset of these if applicable.

Please give a brief explanation of any significant medical, mental health, and learning problems in the immediate and extended family.

## Spirituality

Describe religious/spiritual practices of your family, if any:

## Significant Events

Have any of the following occurred in your family?

<u>Mo/Year</u>	<u>Event</u>	<u>Please Describe</u>
	Move to a new place	
	Change of school for child	
	Separation from parent	
	Serious illness or injury in family	
	Death in family	
	Change in living arrangements	
	Change in family's finances	
	Promotion of parent at work	
	Loss of parental job	
	Change of parental job	
	Parent began work outside home	
	Divorce or marital separation	
	Legal problems	
	Emotional problems in parent	
	Other (specify):	

For significant events listed, what were your child's reactions?