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Developmental History Questionnaire

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To be completed for patients of Dr. Hannah Price's, who are 17 years old or younger.

CHILD'S NAME:	DATE:				
DATE OF BIRTH:	AGE:				
INFORMANT:	RELATIONSHIP:				
PRENATAL HISTORY					
Mother's health during pregnancy	: Good Fa	air Poor	Don't Know		
Age of mother at child's birth					
If there were complications during	g pregnancy, pleas	se describe:			
Were any of the following medicat Alcoholic beverages		es used during	pregnancy?		
Caffeine (coffee, tea, soda)	Frequency:	-			
Cigarettes	Frequency:	-			
Other medications (Please	explain):				
If there were complications during	g delivery, please	explain:			
Was your child born at Full to	erm,wee	ks early,	weeks late?		
Type of delivery: Vaginal (Caesarean section	Induced	Forceps used		
Child's birth weight:					
Child's condition at birth: Good	Fair P	oor Don't k	know		
Did your child require a stay in the	NICU? Please de	escribe if so:			

EARLY DEVELOPMENT

Did your child experience any medical problems during infancy? No Yes If yes, please describe:

Was your child an easy baby, meaning did he or she cry often or follow a schedule fairly well? Very easy Average Difficult Very Difficult

During childhood, did he or she have problems with any of the following?

Hearing Vision Speech Gross motor skills (running, climbing, riding a bike)

Fine motor skills (tying shoes buttoning, coloring, handwriting)

Social Skills

If any of the above categories were checked, please explain:

MEDICAL/HEALTH STATUS

Has your child had any significant health or medical problems? (chronic condition, surgery, injury, hospitalization)? No Yes If yes, please explain:

Has your child had any significant head injury or injury when he or she lost consciousness? No Yes If yes, please explain:

Does your child take any medications regularly? No Yes If yes, please provide name of medication(s), physician who prescribed medication, and duration of use.

Has your child been evaluated or treated by a mental health professional previously? No Yes If yes, please provide relevant information:

Does your ch	nild have any p	oroblems with	sleep?	No	Yes	If yes, please describe		
Child's bedti	ltime: Usual number of hours of sleep:							
Child sleeps	alone:	_ Child sleep	s with: _					
EDUCATION	NAL HISTORY							
Name of chil	d's current sc	hool:				Grade:		
Number of s	chools your cl	nild has attend	led:		-			
Number of g	rades repeate	d:						
If so, please	ld been evalua explain below ped as a result	and bring cop				No Yes IEP's that may have		
Current acad	lemic perform	Fair	-					
•	currently bei	_			No	Yes		
SOCIAL SKII	LLS AND ACT	<u>IVITIES</u>						
How does yo	our child get al	long with fami	ly memb	ers and	other	rs?		
Parents:	Very good	Average	Fair	Poorly				
Siblings:	Very good	Average	Fair	Poorly				
Peers:	Very good	Average	Fair	Poorly				
Does your ch socializes?	nild have a bes No Yes	st friend or a g	roup of fi	riends v	vith w	hom he often		

PLEASE BRING A COPY OF THIS COMPLETED FORM TO THE INITIAL VISIT