Developmental History Questionnaire*

The goal of the Developmental History Questionnaire and related scales you have been ask to have completed is to provide your clinician/treatment team with a comprehensive view of important aspects of your child's life, including significant patterns of problems and strengths. It is being used in concert with several other scales that have been selected to best provide us information about your child Each section of this questionnaire provides important diagnostic information about a specific area of your child's development. Most questions only require you to check off an answer. Additional sections have been provided to allow you to include additional comments.

Please answer as many questions as you are able. The more completely you can respond to the questionsin this questionnaire and other parts of the battery of scales, the clearer our understanding of your child's situation will be, and the better we will be able to meet his or her needs.

This form should take about 15 to 20 minutes to complete. (Please use black ink when responding to the questions.)

Please complete both sides of the questionnaire.

We realize that many of the items in this questionnaire involve personal and private information. Your input regarding your child's treatment is crucial; all questions address topics that are significant and relevant to this treatment. All information is kept strictly confidential, and will not be released to any outside agencies without your permission.

If you have any questions or concerns, please do not hesitate to ask your physician.

We look forward to working with you and your family.

* This form is an abridged version of one developed by University Behavioral HealthCare-UMDNJ

DEVELOPMENTAL HISTORY QUESTIONNAIRE*

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

A. Background Information

1. Parent/Guardians:

Name	*Address*		*Home Phone*
Occupation	*Employer*	*Education*	*Work Phone*
Name	*Address*		*Home Phone*
Occupation	*Employer*	*Education*	*Work Phone*

2. Who currently lives in your child's home? Please include yourself:

Name	*Date of Birth*	*Relationship to Child*

3. List family members (siblings, parents) living **outside** of your child's home:

Name	*Date of Birth*	*Relationship to Child*

4. Who referred you to the RWJ Medical Group?

a. ___ Private mental health counselor
b. ___ Pediatrician
c. ___ Insurance Company
d. ___ School
e. ___ Friend
f. ___ Other:_____

B. School Information

1. Child's current grade in school:_____
2. School and address:_____
3. Current teacher:_____ School phone number:_____
4. Academic problems? ___no ___yes

5. Behavioral problems? ___no ___ yes
6. Is your child classified? ___ no ___ yes Classification/Diagnosis:_____
7. Child Study Team Case Manager: Name:_____ Phone:_____
8. Nature of School experience: Check if positive or negative

	Positive	Negative
Preschool	_____	_____
Kindergarten	_____	_____
Grammar	_____	_____
High School	_____	_____

C. Presenting Problems

1. Why are you bringing your child to treatment at this time? What is your main concern?

_____

_____

2. What is the history of the problem? _____

_____

_____

3. What do you expect from treatment?_____

_____

4. Please check **all current concerns** that you have for your child:

a. ___ Relationship problems at home
b. ___ Has no friends
c. ___ Withdrawn/Unresponsive
d. ___ School problems
e. ___ "Weird" thoughts; believes he/she has unusual ability or power
f. ___ Fears without reason that others are out to get him/her
g. ___ Thinks about/talks about the same thing most of the time; excessively preoccupied
h. ___ Confusion; doesn't know what is happening around him/her
i. ___ Can't pay attention, gets sidetracked
j. ___ Often depressed or sad
k. ___ Loss of interest in things used to enjoy
l. ___ Frightened, nervous, upset easily & often
m. ___ Angry or irritable
n. ___ Cries excessively
o. ___ Victim of sexual abuse, current or past
p. ___ Victim of physical abuse, current or past
q. ___ Bullies others
r. ___ Doesn't listen; difficult
s. ___ Does behaviors over and over and can't stop self
t. ___ Over-active
u. ___ Runaway behavior
v. ___ Destruction of property
w. ___ Firesetting
x. ___ Sexual offenses (inappropriate touching of another person)
y. ___ Cruelty to animals
z. ___ Stealing
aa. ___ Sleep difficulties
bb. ___ Engages in self-injuring behavior (e.g. cutting self, binging/purging)
cc. ___ Chronic lying
dd. ___ Police involved
ee. ___ Involved in gang or gang activity
ff. ___ Expressed thoughts about killing self
gg. ___ Made an attempt or gesture to seriously injure or kill self this past year

hh. ___ Plans to harm others or threatens others

ii. ___ Seriously injured someone

jj. ___ Child has access to firearms

kk. ___ You or others suspect that your child currently uses alcohol or drugs

ll. What substances do you suspect or know that your child has used:

a. ___ cigarettes b. ___ alcohol c. ___ marijuana

d. ___ cocaine e. ___ heroin f. ___ other:__ uses alcohol or drugs _____

5. Recent Stressors in the family (**please include dates where applicable**):

a. ___ Drug abuse

b. ___ Alcohol abuse

c. ___ Money problems

d. ___ Change of residence

e. ___ Change in caregiver's employment

f. ___ Loss of job for parent or guardian

g. ___ New school, change in school

h. ___ The child has seen others get hurt, beat up

i. ___ Physical illness in family member

j. ___ Close family member in prison/jail

k. ___ Homeless/no long-term home

l. ___ Legal Problems

m. ___ Couple/marital problems

n. ___ Separation

o. ___ Divorce

p. ___ Remarriage

q. ___ Domestic violence

r. ___ Birth of family member

s. ___ Child recently hospitalized

t. ___ Friend died or tried to kill self

u. ___ Death of family member/significant other

v. ___ Other:_____

D. Prenatal and Neonatal History

1. When you were pregnant with this child, were you under the care of a physician? ___ yes ___ no
2. This child was pregnancy number ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ other
3. Length of pregnancy: ____ months
4. During the pregnancy, did you experience:

	Yes	*No*	*When*		*Yes*	*No*	*When*
a. Anemia	___	___	_____	g. Flu or virus	___	___	_____
b. High blood pressure	___	___	_____	h. German measles	___	___	_____
c. Gestational diabetes	___	___	_____	i. Accident or injury	___	___	_____
d. Vaginal bleeding	___	___	_____	j. Emotional problems	___	___	_____
e. Toxemia	___	___	_____	k. Risk of miscarriage	___	___	_____
f. Swollen ankles	___	___	_____	l. Other	___	___	_____

5. Did you take medication during pregnancy? ___ no ___ yes

   If yes, please give the name and when taken:_____

6. Was the child active in utero? ___ yes ___ no
7. Did you use drugs or drink alcohol during your pregnancy? ___ no ___ yes

   If yes, please describe what type(s) and when:_____

8. Did you have a Cesarean section? ___ no ___ yes
9. Was your delivery unusual in any way? ___ no ___ yes

If yes, please describe:_____

10. Was your child healthy at birth? ___ yes ___ no

If no, please describe:_____

11. In the first few days after birth, did your baby experience any of the following?

a. ___ yellow jaundice
b. ___ blood transfusion
c. ___ breathing problems
d. ___ incubator time
e. ___ convulsions
f. ___ special nursing care
g. ___ infection
h. ___ receive medication
i. ___ other

12. Did mother and baby leave the hospital together? ___ yes ___ no

13. How long after birth? mother_____ baby_____

E. Developmental History

1. During the first 12 months, was your child:

a. ____ Overactive, in constant motion?
b. ____ Difficult to put on a schedule?
c. ___ Difficult to feed?
d. ___ Difficult to put to sleep?
e. ___ Colicky?

2. What was your baby's activity level? ___high ___average ___low

3.

4. At what approximate age did your child:

a. Sit without help_____
b. Crawl_____
c. Walk alone_____
d. Eat solid food_____
e. Feed self_____
f. Say single words (e.g. mama, dada)_____
g. Talk in 2 word sentences_____
h. Gain bowel control_____
i. Stay dry (day)_____
j. Stay dry (night)_____
k. Smile when played with_____
l. Learn simple games (e.g. peek-a-boo)_____
m. Show shyness with strangers_____

F. History of General Behaviors and Personality Traits

Please check characteristics that describe your child in the past and/or present

1. ___ Shy or timid
2. ___ Disliked attention
3. ___ Unfriendly
4. ___ Unaffectionate
5. ___ Stubborn
6. ___ Eating difficulties
7. ___ Temper tantrums
8. ___ Right-handed
9. ___ Left-handed
10. ___ Falling spells
11. ___ Daredevil behavior
12. ___ Unusual fears
13. ___ Rocking
14. ___ Clumsy
15. ___ Head banging
16. ___ Blank spells
17. ___ Distactible
18. ___ Short attention span
19. ___ Impulsive
20. ___ Sleep Problems
21. ___ Destroyed toys more than normal
22. ___ More interested in things than people
23. ___ Poor gross motor coordination
24. ___ Poor fine motor coordination

25. Intensity of expression of mood: ___ High ___ Moderate ___ Low

26. General mood: ___ Positive ___ Negative
27. Response to new things: ___ Withdraw ___ Approach
28. Time for adaptation to change: ___ Short ___ Moderate ___ Long

G. Medical History

Please check all that apply.

1. ___ Allergies, describe:_____
2. ___ Takes non-psychiatric medicine
   - Medication 1: Type and dose:_____
     Prescribed by:_____
   - Medication 2: Type and dose:_____
     Prescribed by:_____
   - Medication 3: Type and dose:_____
     Prescribed by:_____
3. ___ Serious infectious disease
4. ___ Diabetes
5. ___ Thyroid problem
6. ___ Cardiovascular problems
7. ___ Seizure disorder
8. ___ Head injury
9. ___ Tic disorder
10. ___ Medical hospitalizations, specify dates and reasons:_____
11. ___ Complains of stomach aches
12. ___ Can't get to sleep
13. ___ Can't stay asleep, wakes up a lot
14. ___ Wets the bed at night or clothing during the day
15. ___ Soils his/her pants in bed or during the day
16. ___ Often complains of body pains or being sick
17. ___ Significant weight change, specify:_____
18. ___ Speech problems, specify:_____
19. ___ Hearing difficulty, specify:_____
20. ___ Frequent ear infections
21. ___ Vision problem, specify:_____
22. ___ Serious accident or injury, specify:_____
23. ___ Major surgery, specify date and type:_____
24. ___ Asthma-breathing attacks
25. ___ Dental problems
26. ___ Other, specify_____
27. Are you child's immunizations up to date? ___ yes ___ no
28. Name of child's physician: _____ Phone number :_____
29. Date of last doctor's physical examination and results: _____

30. **Please initial and date if we have your permission to send a brief summary to your younngster's physician with our working diagnosis and proposed plan of treatment.** Initials _____ Date signend_____

If your youngster is 16 years or older, we ask for their permission as well. Patient initiakss _____ Date signed _____

H. Past Psychiatric Illness and Treatment

1. ___ Child received outpatient counseling
   a. Diagnosis:_____
   b. Dates of treatment:_____
   c. Name, phone # of previous or current counselors:_____
2. ___ Child was hospitalized in psychiatric setting
   a. Diagnosis:_____
   b. Dates of treatment:_____
   c. Name, phone # of facility:_____
3. ___ Child is receiving additional support services (CART, YAP, ICM, FCIU etc.)
4. ___ Child **was prescribed psychiatric medication**

Medication 1: Name and dose:_____
Prescribed by:_____ Date_____

Medication 2: Name and dose:_____
Prescribed by:_____ Date_____

Medication 3: Name and dose:_____
Prescribed by:_____ Date_____

Medication 4: Name and dose:_____
Prescribed by:_____ Date_____

Medication 5: Name and dose:_____
Prescribed by:_____ Date_____

I. Family History

1. Mother: a. ___living b. ___deceased (cause of death, if known: _____) c. ___unknown
2. Father: a. ___living b. ___deceased (cause of death, if known: _____) c. ___unknown
3. Check below if any family members have experienced the following (indicate the relationship to the child, and include child's parents, brothers, sisters, aunts, uncles, cousins and grandparents):

		Relatives
a.	_____Devclopmental disability	_____
b.	_____Physical Disability	_____
c.	_____Depression	_____
d.	_____Anxiety	_____
e.	_____ Bipolar/Manic Depression	_____
f.	_____Psychiatric Hospitalization	_____
g.	_____Alcohol or drug addiction	_____
h.	_____Learning problem	_____
i.	_____Problem with Attention	_____

j. _____Physical/Sexual Abuse _____

k. _____Suicide or Suicide attempts _____

l. _____Other Mental illness _____

4. Is your child or family currently involved with DYFS? ___ no ___ yes
5. Is your child or family currently legally involved or on Probation? ___ no ___ yes
6. Is your child adopted? ___ no ___ yes
7. Is anyone else in the family adopted? ___ no ___ yes - whom?_____
8. Languages spoken at home:_____
9. Religious Affiliation:

   a.___ Catholic b.___Protestant c.___Jewish d.___Muslim e.___Other:_____

10. Religiously Committed: ___ yes ___ no
11. Has the child ever been in any out-of-home placement? ___ yes ___ no

    Explain:_____

12. Are there guns in the home? ___ yes ___ no

J. Strengths

1. What are your child's strengths?

a. ___ Manages emotions well	g. ___ Self-disciplined	m. ___ Does well in school
b. ___ Responsible	h. ___ Interpersonal skills	n. ___ Entertains self
c. ___ Cooperative	i. ___ Insightful	o. ___Other:_____
d. ___ Artistic/Creative	j. ___ Articulate	p. ___Other:_____
e. ___ Motivated	k. ___ Wants to please others	
f. ___ Intelligent	l. ___ Plays sports	

K. Additional Comments

_____

_____

_____

_____

THANK YOU!

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