LONG GROVE CENTER FOR
Emotional Health

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DEVELOPMENTALQUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis.

Please complete these forms as best as you can. We will have the opportunity to discuss them in detail at the time of your child's appointment.

Please circle or write in your answer to the following questions.

PLEASE PRINT

Child's Name_____Date of Birth_____Age_____

Today's date_____

Person completing form_____Your Relationship to Child_____

Mother's Name_____ Work

Phone_____

Home Phone_____ Cell Phone_____

Address/City/State/Zip_____

Father's Name_____ Work Phone_____

Home Phone_____ Cell Phone_____

Address/City/State/Zip_____

Is this your biological, adopted, step, foster, other_____

child?

If adopted, how old was the child when s/he was adopted?_____

Are you the child's legal guardian? If no, please explain Yes No

Name of Guardian_____

Work Phone_____ Home Phone_____

Address/City/State/Zip_____

Referred by_____Phone_____

Address/City/State/Zip_____

Child under medical care of (physician) name and phone_____

Address/City/State/Zip_____

Have you notified the child's physician of your appointment here? Yes No

MOTHER'S MARITAL STATUS

Married:
How many times have you been married?_____
How long have you been married to your current spouse?_____

Separated:
How long did you live with your spouse before you separated?_____
How long have you been separated?_____

Divorced:
How long were you married to your (last) spouse?_____
How long have you been divorced?_____

Widowed

Never Married

Other
Please Explain: _____
_____

FATHER'S MARITAL STATUS

Married:
How many times have you been married?_____
How long have you been married to your current spouse?_____

Separated:
How long did you live with your spouse before you separated?_____
How long have you been separated?_____

Divorced:
How long were you married to your (last) spouse?_____
How long have you been divorced?_____

Widowed

Never Married

Other
Please Explain:

_____
_____

Others in the Home:

Name	Age	Birth Date	Relationship to Patient

Siblings who have moved out of the home:

Name	Age	Birth Date	Relationship to Patient

Do any other family members (e.g. mother, father, brother, sister, aunt, uncle, etc.) suffer from a problem with inattentiveness/hyperactivity, psychological, emotional, learning problem, and/or nervous disorder, etc?

Family member's relationship to child	Current Age	Type of Problem	Severity? e.g. mild, severe, etc.	Type of treatment

ADHD QUESTIONNAIRE

Do you believe this child has it in him/her to exert control over behavior and attention?
Yes No
Please explain:

Do you see this child as being hyperactive or as having problems with attention and concentration? Yes No
If yes, please explain:

Has this child ever been diagnosed by a School Psychologist or other professional (e.g. mental health clinician/physician) as having ADHD? Yes No
If yes, please explain:

Has your child ever been previously evaluated specifically for ADHD? Yes No
If yes, please explain:

Has this child received treatment for ADHD? Yes No
If yes, please explain:

Please list the names of the medications and dosage the child is given on a daily basis:

How long has the child been on medication?

Has the child experienced any problems while on medication? Yes No
If yes, please explain:

Have you ever discussed this child's problems with a physician? Yes No

What are your concerns for this child? What are the difficulties/problems that cause you to seek help at this time?

CHILD'S EDUCATIONAL PLACEMENT

Name of School_____ School District_____ Grade_____

Type of Classroom Placement (e.g. regular, ED, LD, Resource Room, etc.):

_____

Approximately how many children are in this child's class?_____

Check all those official school classifications which apply to this child:

_____Learning Disabled

_____Emotionally Disturbed

_____Mentally Retarded/Intellectually Limited

_____Visually Impaired

_____Hearing Impaired

_____Physically Handicapped

_____Other:_____

Teacher's Name_____

Resource Teacher's Name_____

Principal's Name_____

School Counselor's Name_____

The name(s), address(es) and phone number(s) of any other person involved in this child's education that you feel we should contact:

Did this child attend any type of preschool program? Yes No
If yes, what type of program, what age did s/he begin, and the frequency of attendance?
(Example) Nursery School: age 4, 2x/week/2hr sessions

Did this child experience any problems in preschool? Yes No
If yes, please describe:

Did this child repeat any grades? Yes No
If yes, what was the reason for repeating that particular grade?

Did this child fail any subjects? Yes No
If yes, which ones?

Does this child currently receive any special educational services? Yes No
If yes, specify type (e.g. self-contained class, resource room, reading or math lab, etc.):

Frequency of attendance in special classes (e.g. full-time placement, 1x/day/30 minute sessions):

Please list or discuss any other school problems:

MOTHER'S FAMILY HISTORY

Name_____

Birth Date_____Birth Place_____

Age_____Religion_____

Highest Grade Completed_____Highest Degree_____

Were you ever in any type of special education class? Yes No
If yes, please explain:

Have you experienced difficulties with reading? Yes No
If yes, please explain:

Have you experienced difficulties with writing? Yes No
If yes, please explain:

Have you experienced difficulties with math? Yes No
If yes, please explain:

Generally, what sort of student were you gradewise?_____A/B_____B/C_____C/D_____D/F

Did you repeat any grades? Yes No
If yes, which ones and the reason for repeating the grade.

Did you fail any subjects? Yes No
If yes, which ones?

Any behavior problems? Yes No
If yes, please specify.

Any mental health problems for which you have received treatment? Yes No
If yes, please describe the problem and the treatment you received.

Have you ever been told, or thought yourself, that you might have an attention deficit or be hyperactive? Yes No

Any medical problems? Yes No
If yes, please specify:

If yes, how old was your child when they began?_____

Your age at the time of your pregnancy with this child_____

TOTAL number of pregnancies_____ Number of previous pregnancies_____

Number of miscarriages_____ Number of induced abortions_____

Occupation_____

Current place of employment_____

During what years of child's life have you worked?_____

_____

Previous work history:

_____

_____

_____

_____

_____

_____

FATHER'S FAMILY HISTORY

Name_____

Birth Date_____Birth Place_____

Age_____Religion_____

Highest Grade Completed_____Highest Degree_____

Were you ever in any type of special education class? Yes No
If yes, please explain:

Have you experienced difficulties with reading? Yes No
If yes, please explain:

Have you experienced difficulties with writing? Yes No
If yes, please explain:

Have you experienced difficulties with math? Yes No
If yes, please explain:

Generally, what sort of student were you gradewise?_____A/B_____B/C_____C/D_____D/F

Did you repeat any grades? Yes No
If yes, which ones and the reason for repeating the grade.

Did you fail any subjects? Yes No
If yes, which ones?

Any behavior problems? Yes No
If yes, please specify.

Any mental health problems for which you have received treatment? Yes No
If yes, please describe the problem and the treatment you received.

Have you ever been told, or thought yourself, that you might have an attention deficit or be hyperactive? Yes No

Any medical problems? Yes No
If yes, please specify:

If yes, how old was your child when they began?_____

Do you smoke cigarettes? Yes No
If yes, please specify average number of cigarettes per day.

Do you drink alcohol? Yes No
If yes, what type of alcohol do you drink and how much per day?

Do you currently use any type of drugs? Yes No
If yes, what type of drugs do you use and how much per day?

Occupation_____

Current place of employment_____

During what years of child's life have you worked?_____

_____

Previous work history:

_____

_____

_____

_____

CHILD'S DEVELOPMENTAL HISTORY

Pregnancy

Length in months (or weeks) if known_____

X-Ray studies? Yes No
If yes, when during your pregnancies and what type of X-Ray?

Were any medications used during pregnancy? Yes No
If yes, please specify:

Did you smoke cigarettes during pregnancy? Yes
No
If yes, please specify average number of cigarettes per day.

Did you drink alcohol prior to pregnancy? Yes No
If yes, what type of alcohol did you drink and how much per day?

Do you currently drink alcohol? Yes No
If yes, what type of alcohol do you drink and how much do you drink per day?

Did you use any type of drugs during pregnancy? Yes No
If yes, what type of drugs did you use and how much per day?

Do you currently use any type of drugs? Yes No
If yes, what type of drugs do you use and how much per day do you take?

Pregnancy Complications (check all those that apply):

_____bleeding _____high blood pressure

_____excessive vomiting _____sonograms

_____excessive weight gain _____rash

_____infections _____swelling

_____weight loss _____fever

_____kidney trouble _____toxemia

_____diabetes

_____other:_____

Delivery

Type of Labor: _____spontaneous _____induced

If labor was induced, please specify reason for induction.

Type of birth delivery: _____normal _____breech _____Cesarean section

Duration of labor: _____hours

Check all those that apply:

_____forceps used

_____hemorrhage/excessive blood loss

_____multiple birth

_____baby born in some sort of danger (e.g. cord around the baby's neck, heart rate problems, etc.)

Please specify:_____

Anesthesia:

_____none _____general

_____local anesthetic (e.g. epidural/spinal) _____muscle relaxant

Were there any problems with labor and/or delivery? Yes No
If yes, please specify:

Perinatal History

Baby's weight at birth: _____ pounds _____ounces

Baby's length at birth: _____inches

Number of days baby stayed in the hospital following his/her birth: _____ days

Number of days mother stayed in the hospital following the baby's birth: _____ days

APGAR score, if known, at birth: _____ At 5 minutes: _____

Check those that apply:

_____jaundice _____very quiet

_____incubator _____very active

_____blood transfusion (baby) _____problems sucking

_____rashes _____problems eating/digestion

_____problems breathing _____baby on heart monitor

_____baby given oxygen _____Other: _____

Any birth defects? Yes No
If yes, please explain:

Any other problems or comments regarding this child when he/she was a newborn? Yes No
If yes, please specify:

Any other problems or difficulties around the birth? Yes No
If yes, please specify:

How worried were your doctors about the overall health of the baby within the first few days?

Infancy and Early Childhood:

Check all that apply.			If yes, please specify below.
Colicky	Yes	No	
Feeding Problems	Yes	No	
Sleeping Problems	Yes	No	
Restless	Yes	No	
Active	Yes	No	
Did not enjoy cuddling	Yes	No	
Head banging	Yes	No	
Accident prone	Yes	No	
Uncoordinated	Yes	No	

Are there any other problems or comments regarding this child's infancy and early childhood development? Yes No

If yes, please specify:

Child's approximate age when s/he began:

Walking: _____ months

Talking (single words): _____ years

Talking (short sentences of 2+ words): _____years

Toilet training: daytime_____years nighttime_____years

Does this child continue to have wetting accidents in bed? Yes No
(day and/or night)

Does this child continue to have wetting accidents in clothing? Yes No
(day and/or night)

Does this child continue to have soiling accidents in bed? Yes No
(day and/or night)

Does this child continue to have soiling accidents in clothing? Yes No
(day and/or night)

If yes to any of the questions above, please explain:

Overall, do you feel this child developed at a _____ slow, _____ normal, _____ rapid rate?
Please explain:

Childhood Diseases

Check all those that apply. In the extra space provided, please describe the condition, and specify the type of treatment s/he received and if this child continues to receive treatment for the condition.

_____Asthma

_____Anemia

_____Lead Poisoning

_____Meningitis

_____Seizures

_____Epilepsy

_____Hydrocephalus

_____Cerebral Palsy

_____Mental Retardation

_____Heart Problems

_____Emotional Problems

_____Vision Difficulties

_____Hearing Difficulties

Any other handicapped conditions or special health considerations? Yes No
If yes, please explain:

Has this child ever been taken to the Emergency Room? Yes No
If yes, please list why your child was taken to the ER and how old s/he was at the time of the visit.

Has the child undergone any type of surgery? Yes No
If yes, please specify a) type of surgery, b) age, and c) the length of stay

Was your child hospitalized for any other type of illness thus far not recovered? Yes No
If yes, please specify a) reason for hospitalization, b) age, and c) the length of stay

Has this child suffered any type of head injury? Yes No
If yes, please indicate whether or not consciousness was lost and your child's age at the time of the incident.

Has your child experienced any convulsions? Yes No
Indicate the nature of the convulsions and whether or not these occurred with high fevers. Please indicate the child's age at the time of the convulsions.

What was the highest fever this child ever had? What was the nature of the illness associated with this fever?

Has this child experienced consistent high fevers? Yes No
If yes, please explain.

Was this child ever in a coma? Yes No
If yes, please explain.

Does this child suffer from allergies? Yes No
If yes, please explain the type of allergic reaction and the treatment s/he is receiving, if any.

Has this child ever suffered from any type of poisoning? Yes No
If yes, please explain.

Has this child suffered from ear infections? Yes No
If yes, please explain.

This child's age at the time of his/her first ear infection (approximately):_____

This child's age at the time of his or her most recent ear infection (approximately):_____

The types of medical treatment this child has received for his/her infections (e.g. antibiotics, antihistamines, tubes, etc.):

Total number of ear infections (approximately):_____

As best as you can recall, please indicate the number of ear infections which occurred during the following stages of this child's development and the type of treatment he or she received during that age range.

	Number of Infections	Type of Treatment
Birth - 2 years		
2 - 5 years		
5 years and above		

Child's Present Medical Status:

Current health: _____ poor _____ fair _____ good _____ excellent

Child's present height: _____ feet _____ inches

Child's present weight: _____ pounds

Is this child in any way physically ill at this time? Yes No
If yes, please explain and tell us how your child is currently being treated for this illness.

Is this child taking any type of medication at this time? Yes No
If yes, please explain:

Has this child ever taken any type of medication on an ongoing basis? Yes No
If yes, please name the medication(s) and provide the doses and frequency of administration.

Has this child ever been involved in any type of professional mental health treatment? Yes No
If yes, please provide a) the name of therapist, b) duration, and c) purpose of therapy.

Is this child currently involved in any type of professional mental health treatment? Yes No
(e.g. psychotherapy, family counseling sessions, etc.).
If yes, please provide a) the name of therapist, b) duration, c) purpose of therapy.

Is this child currently (or in the past) had occupational, physical, or speech therapy? Yes No
If yes, please provide a) the name of therapist, b) duration, c) purpose of therapy.

Please list any unusual and/or traumatic family event in this child's life which you feel may have affected his/her development and ability to function (for example: birth of a sibling, deaths in the family, divorce, illnesses, frequent school changes, moves, etc.).

Incident	Child's Age	Comments