



LONG GROVE CENTER FOR
Emotional Health

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DEVELOPMENTAL QUESTIONNAIRE

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

_____ Visually Impaired

_____ Emotionally Disturbed

_____ Hearing Impaired

_____ Mentally Retarded/Intellectually Limited

_____ 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 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: _____

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

- 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
