Christine E. Agee, Ph.D.
2200 Lakeshore Drive, Suite 150
Birmingham, AL 35209

PHONE: (205) 871-6926 **FAX: (205) 871-7981**

DEVELOPMENTAL QUESTIONNAIRE

Child's Name:____ DOB:__________________________________ Age:_____________________

Are you the legal guardian? _____(name of guardian if no) _________________________________This is my __biological __adopted ___step __foster ___grand child.

Parents' and Stepparents' Names and Ages____

Siblings' and Step-Siblings' Names and Ages____

Others in Home:____ Marital status of parents:____

If divorced, list dates of separation, divorce, and any remarriage. ____

____

If divorced, list name, address and phone number of noncustodial parent and visitation schedule: ______________________________________

____

REFERRED BY: ____

Pediatrician's name and address:____

REASON FOR REFERRAL: (Describe areas of major concern)

1) ____

2) ____

3) ____

How long have these problems existed? _________Began recently __________About a year __________More than a year

Have you seen other professionals for help with these or other problems (if so, please list)? ____

SCHOOL HISTORY:

Present school, address, and phone number____

Grade:__________________________________ Teacher(s):____

Previous schools attended:____

____

Day care or after school programs:____

Does this child have difficulties in __________Reading __________Math ___________Writing ___________Behavior __________All ___________None

Is school absence a problem? Yes__________ No__________ Grades repeated and reason:____

____

In what kind of school program is this child presently enrolled?

Regular Class_______________ Special Ed Program________________ (Please describe type)____

School-related Problems: (Check all that you know of)

Slow learner	Doesn't concentrate/Easily distracted	Comes to class without materials
Perfectionistic	Doesn't keep track of assignments	Nervous/Worried about tests
Suspended or expelled	Doesn't get along with classmates	Locker/desk/backpack is disorganized
Bored with classwork	Misbehaves in class/disobedient	Late to school or class
Disrupts class or disturbs others	Poor attitude or apathetic	Sleeps or is drowsy during class
Attention seeking	Difficulty with homework	Doesn't turn in homework/hands in late
Doesn't retain information	Resists authority	Asks too many questions

Other problems with school: (Please describe) ____

____

____

Homework/study time: (Please rate your child's homework habits N/A = Not Applicable 1=Never 2=A little 3=Sometimes 4=Often)

	Uses an assignment book, planner or calendar		Does homework in a quiet, non-distracting environment		Keeps notebooks, paper study area organized & accessible		Requires a lot of parental supervision during homework/studying
	Keeps track of own grades		Spends enough time studying		Completes homework on time		Spends enough time on homework
	Uses study aids effectively (e.g.,flash cards, mnemonics)		Brings necessary books/materials home to complete assignments		Says completed work is "good enough"		Complains excessively and wastes time during homework
	Makes careless errors		Too worried about grades		Overly perfectionistic on tasks		Missing/incomplete homework
	Zones out		Procrastinates		Has trouble memorizing		Asks for help appropriately
	Gives up too easily		Other problems:				

What comments or concerns have teachers made about the child over the years?

Comments ______________________ Teacher/Grade ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Has your child ever received tutoring? ___________No __________Yes (Reason/focus)______________________

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HEALTH AND DEVELOPMENTAL HISTORY:

Prenatal and Birth: (Check all that occurred during mother's pregnancy and delivery)

Maternal bleeding	Large weight gain	Toxemia/Pre-eclampsia
Rh Factor incompatibility	Serious illness or injury during pregnancy	Prescription medications (list)
Smoked cigarettes	Drank alcohol	Took illegal drugs
Induced delivery	Baby was premature (how early)	C-section
Baby injured during delivery	Trouble breathing/Needed oxygen	Born with congenital defect
Heart distress during/after delivery	Jaundiced or cyanotic	Birth weight (how much)
Other complications during pregnancy	Other complications during delivery	Baby had seizures

Other comments____

Infancy and Toddlerhood: (Check all that apply)

Colicky	Difficult to feed/Feeding problems	Difficulty getting to sleep/Sleeping problems
Overly restless/active	Didn't enjoy cuddling	Difficult to comfort
Mother had post-partem depression	Head banging	Easy temperament
Nervous temperament	Difficult temperament	Sociable

Other observations during this time period:____

____

Health History: (Check all that apply)

Frequent Diarrhea	Persistent Headaches	Pneumonia
Constipation	Concussion	Bronchitis
Stomach aches	Other Head Injuries	Asthma
Recurrent Abdominal Pain	Seizures	Allergies
Urinary Infections	High Fevers	Tonsillitis
Surgery (describe)	Meningitis	Excessive Fatigue
Cerebral Palsy	Lead Poisoning	Frequent Colds
Heart Murmur or Heart Problems	Appetite Problems`	Anemia
Broken Bones	Diabetes	Weight loss/gain

Other illnesses or injuries____

Hospitalizations/emergency room visits____

Current medications/reason ____

Previous medications/reason:____

Date of last medical checkup or visit:____

Sleeping and Eating Habits: (Check all that apply within the last year and currently, and supply needed information)

Nightmares/Night Terrors	Sleeps Excessively	Talks in Sleep	Insomnia/Trouble Falling Asleep
Restless Sleep	Sleepwalking	Trouble Sleeping by Self	Snores when Sleeping
Bedtime routine includes TV/video	Eats Between Meals	Overweight/Eats Excessively	Unusual Eating Habits
Good Appetite	Vegetarian	Picky Eater	Sneaks Food
Bed wetting	Bedtime Hour:	Average hours of sleep per night:	

What are the child's favorite beverages and foods?____

Does the child have caffeinated beverages? _________No _________Yes (Amount): ______________________________________

Please list whether the child was on time (O), early (E) or late (L) achieving these developmental tasks:

____Walking ____Talking (single words) ____Talking (sentences) ____Tying shoes ____Riding a two-wheeled bicycle ____ Toilet training

How is this child's current gross-motor coordination (e.g., running, throwing, jumping, skipping) ? _______Good_______ Average________ Poor

How are this child's fine motor skills (coloring, writing, using scissors, tying shoes, buttoning)? _______ Good_______ Average_______ _Poor

Handedness: Right-handed_________ Left-handed_________ Ambidextrous__________

Daytime wetting: Never________ Occasionally_________ Frequently________

Other toileting issues: ____

Speech and Language Development: (check if the child struggles with any below)

Naming Objects or pictures	Repeating words or sentences	Following one step directions
Following complex directions	Understanding what is said	Answering questions
Asking Questions	Staying on topic of conversations	Losing train of thought
Finishing a Sentence	Finding the right word	Trouble pronouncing words

Has the child had a speech/language assessment? (Year/Results)____

Hearing and Vision: (Check those that apply)

Frequent ear infections before age two	Complains of ringing or buzzing noises in ears	Dizzy spells
Complains he/she can't hear	Overly sensitive to certain noises/sounds	Wears a hearing aid
Hearing or vision defect at birth	Near sighted	Far sighted
Glasses prescribed	Strabismus (crossed eye)	Amblyopia (lazy eye)

Has the child had a hearing exam? (Year/Results) ____

FAMILY HISTORY:

List any family members (e.g., mother, father, siblings, aunts, uncles, grandparents) who have had problems with learning (ADHD, learning disabilities, developmental delay) or psychological or emotional functioning (e.g., anger/aggression; anxiety; depression; psychosis; addiction/substance abuse; sexual abuse; suicide attempts):

____

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____

Biological mother's education:

	Highest Grade /degree completed	Y/N	Emotional problems as a child? (explain)
Y/N	Repeat any grades? (If Y, which grades)	Y/N	Behavioral problems as a child? (explain)
Y/N	Problems with math?	Y/N	Medical Problems as a child? (explain)
Y/N	Problems with reading?		Current occupation:
Y/N	Problems with writing?		Previous occupation:

Biological Father's education:

	Highest Grade /degree completed	Y/N	Emotional problems as a child? (explain)
Y/N	Repeat any grades? (If Y, which grades)	Y/N	Behavioral problems as a child? (explain)
Y/N	Problems with math?	Y/N	Medical Problems as a child? (explain)
Y/N	Problems with reading?		Current occupation:
Y/N	Problems with writing?		Previous occupation:

CHILD'S EMOTIONAL DEVELOPMENT AND BEHAVIOR:

(Please check all that apply if they are sufficient to be considered a problem.)

Too Dependent	Excessive Fears	Temper Tantrums	Shy and Withdrawn	Hyperactive
Suspicious/Mistrustful	Stealing	Lying	Lonely	Poor Concentration
Difficulty Choosing/Deciding	Feelings Easily Hurt	Hits and Shoves Others	Feels Overly Guilty	Uses alcohol or drugs
Eye Blinking/Tics	Oppositional or Defiant	Chronic Anger	Excessive Crying	Destroys things on Purpose
Worries about Future	Demands Attention/Jealous	Hurts Others' Feelings	Daydreaming	Poor Social Skills
Repeats Self Over and Over	Sexual Behavior	Perfectionistic	Low Self Esteem	Harms Animals Purposely
Smokes cigarettes	Unusual Habits/Preferences	Difficulty with Transitions	Other Problems:	

What are your main discipline strategies, and how well do they work?____

Is there disagreement about discipline? ____

How well do they work?____

Please list any events which may have affected your child's development and/or current functioning (e.g., birth of sibling; deaths; divorces/separations; maltreatment; bullying by others; illnesses; school changes; family moves; accidents; disasters; witness to violence, etc.)

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____

____

ACTIVITIES:

What are your child's extracurricular activities (teams, clubs, jobs, special interests)?__________________________________

____

Please estimate the average amount of time the items below occur:

	Minutes per day child reads alone for pleasure		Nights per week the family eats dinner together
	Hours per week child uses touch-screen phone or tablet		Times per year family participates in family activities (picnics, games)
	Hours per week child plays video games		Times per year family participates in educational activities (zoo, museums, library)
	Hours per week child watches television		Frequency per week that the child receives verbal encouragement
	Minutes per day child has physical exercise (not including PE)		Minutes per day parent reads aloud to child
	Hours per week child plays with friends		Minutes per week child works on chores

Does your child have access to the internet?____________ What does he/she do on the internet (e.g., games, social media, you tube videos) and for how much time?

____

Does your child have a television or computer in their room? ____

MISCELLANEOUS

Please list any other concerns, comments or other information you would like me to know about: ____________________________

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Name of person completing this form:______________________________Date completed: ______________________

THANK YOU FOR COMPLETING THIS FORM! PLEASE BE SURE TO REVIEW YOUR ANSWERS AND COMPLETE ANY MISSING INFORMATION