SUNSET COUNSELING CENTER
• I N C O R P O R A T E D •

CHILD DEVELOPMENT HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Child's Name:	☐ M ☐ F	**DOB:**
Previous or referring doctor:	**Date of Last Developmental Exam:**	

FAMILY STRUCTURE

Mother's/Guardian's Name____ Age_______ Living with child Not living with child

Employment____________________ Occupation____ Employed currently? Yes No

Father's/Guardian's Name____ Age_______ Living with child Not living with child
Employment____________________ Occupation____ Employed currently? Yes No

Parents are ( ) Single Married Partnered Separated Divorced Widowed Other__________________________________

If child is not living with parent(s), please explain circumstances:____

Who are the members of your child's family/household?

Name	Age	Relationship

Is there anything else you would like use to know or be aware of with regards to your child's family?
____

____

____

Client Name: ______________________

PREGNANCY & BIRTH HISTORY

Is your child adopted? Yes At what age?________________ Domestic International (Country:_____________________________)

Complications during pregnancy? ____ Full-term Premature

Complications during birth?____

Child's weight at birth? ______lbs. ______oz. Child's health at birth? ____

Length of Hospital Stay? ____ Postpartum depression? Yes No

HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	

Was your infant Calm Fussy Colicky Easily comforted Hard to comfort?

Describe:____

Did you child have any difficulties with Feeding Sleeping Bonding Other?

Describe:____

Does your child have any health issues? Yes No

Describe:____

Does your child take any medication? Yes No

Give name/dose/frequency ____

Has your child ever had a Serious accident/illness or Hospitalization? Yes No

Hospitalizations	
Reason	Date/Hospital
Other Serious Accidents/Illnesses	
Reason	Date/Location

Client Name: ______________________

Did/does your child have Recurrent ear infections? Have tubes in his/her ears? Yes No

Describe:____

Did/ does your child have Allergies? Yes No

Describle:____

Does/did your child have asthma? Yes No

Describe Treatment?____

Has your child had a Hearing Screening Vision Screening Speech/Language Screening? Yes No

Outcome/Date(s):____

____

DEVELOPMENTAL MILESTONES

As accurately as you can remember, how old was your child when s/he: Rolled Over_________ Sat up _________

Creeped________ Cruised__________Crawled _________ Walked _________Talked (2 words)______ Weaned (bottle/breast)_______

Fed self (spoon) _______ Drank from a cup________ Toilet trained: Started______ Completed______

Does/did your child dislike any of the following position(s)? Yes No

Lying on stomach Describe:____

Lying on back Describe:____

How long did your child spend crawling as main form of mobility? ____

Was/Is your child fed? g-tube bottle breast fed? How long? ____

Does your child use a pacifier suck thumb use a bottle? How often? ____

How would you describe your child's feeding/diet?

Normal Picky Eater Restricted Diet Poor Nutrition Unsafe Limited Other

Describe (list preferred foods, concerns):____

____

Do you have concerns about your child's development in *any* of these areas?

Speech or Language Motor Skills Social Skills Cognitive (Intellectual) Sensory Behavioral Emotional

Describe:____

____

Does your child have any developmental delays or special needs? Yes No

Describe:____

____

Has your child had a developmental or diagnostic assessment? Yes No

List (name of facility, date, results): ________________________________

____

Does your child receive any special services (*i.e.: Speech, O.T., Behavior Therapy, etc.)*? Yes No

Describe:____

CHILD'S DAILY ROUTINE

What is the best time of day for you with your child? ____________________________

Eating

Does your child feed him/herself? Yes No

Describe:____

List typical eating/feeding times: __________________________________

Diapering/Toileting

Is your child toilet trained? Yes No "In progress"

Describe Concerns:____

Dressing/Hygiene/Grooming

Does your child get dressed by themselves? Yes No "In progress"

Describe Concerns: ____

Does your child have difficulties with tooth brushing, hand washing, washing hair, bathing, showering? Yes No "In progress"

Describe Concerns: ____

Does your child have difficulties with hair brushing, haircuts, or nails trimmed ? Yes No "In progress"

Describe Concerns: ____

Sleeping

Describe your child's sleeping arrangement:______________________________

Does your child go to sleep easily with difficulty with a bottle with a parent have a bedtime ritual?

Describe:____

Does your child have a regular bedtime? Yes No Wakes at:________ Naps at:_______ Goes to bed at:________

Activities and Play

What are your child's favorite activities at home? ____

____

Where does your child usually play? ____

Does your child *avoid* any physical activities? Yes No

Describe:____

Does your child attend any other regular groups or classes? Yes No

Describe:____

Does your child demand a lot of adult attention? Yes No

Describe:____

Social Relationships

Who are the most important people in your child's life? ____

____

Does your child usually play alone w/siblings w/peers w/ younger children w/older children w/adults?

When are your child's opportunities to play with other children? ____

Does your child have a hard time making friends? Yes No

Describe:____

What adult does your child spend the most time with? ____

Day Care/Preschool

Is your child currently in childcare?

When/Where?____

Is your child currently enrolled in school?

When/Where?____

Does your child have an Individualized Education Plan (IEP)? Yes No

Do you have concerns regarding school performance? Yes No

Describe:____

____

____

CHILD'S TEMPERMENT & PERSONALITY

How does your child handle separation/transitions? ____

What works best?____

Is your child attached to any special objects? ____

Does your child have any fears? ____

How does your child express these fears? ____

What helps? ____

When does your child get upset/angry? ____

____

How does s/he express anger? ____

How do you respond? ____

Describe your child's typical temperament?

Energy — Sedentary Active Very active

Describe:____

First Reaction (to new people, activities, ideas) — Avoidant Shy Outgoing

Describe:____

Mood (general emotional tone) — anxious timid curious serious happy other:_______________

Describe:____

Intensity (strength of emotional reactions) — withdraw mild reactions Strong reactions

Describe:____

Persistence (ease of stopping when involved in an activity) — hard easily redirected hard to focus on an activity

Describe:____

Sensitivity (to noises, emotions, tastes, textures, stress) — not sensitive mild Very sensitive

Describe:____

Perceptiveness (notices people, noises, objects) — hardly ever notices turns to looks/notices overly perceptive

Describe:____

Adaptability (copes with transitions, changes in routine) — slow flexible quickly

Describe:____

Attention Span/Distractibility easily distracted sometimes distracted stays focused

Describe:____

Additional Comments: ____

____

PARENT COMMENTS

How would you describe parenting your child? ____

What do you find the most challenging or stressful in parenting your child? ____

____

What kind of discipline do you use and what works best with your child? ____

____

What has been most joyful for you in parenting your child? ____

____

What are your goals for your child? ____

____

Is there anything else you would like us to know about your child? ____

____

Thank you for taking the time to complete this form..

Parent Signature____ **Date**__________________