DEVELOPMENTAL FACTORS

IF YOUR CHILD HAS BEEN SEEN AT THEDACARE BEHAVIORAL HEALTH IN THE PAST, PLEASE COMPLETE ITEMS 29-46 ONLY. THANK YOU.

Child/Adolescent's Name: _____
DOB: _____
Name of Person Completing Form: _____
Relations to Child/Adolescent: _____
***Note: If the mother of the child/adolescent is not completing the form, please answer to the best of your knowledge.**

A. Prenatal History

1. How was your health during pregnancy?
   _____ Good _____ Fair _____ Poor _____ Don't Know

2. How old were you when your child was born?
   ___ Under 20 ___ 20-24 ___ 25-29 ___ 30-34 ___ 35-39 ___ Over 40
   ___ Don't Know

Do you recall using any of the following substances or medications during pregnancy?

3. Beer or Wine
   (1) Never (2) Once or Twice (3) 3-9 Times (4) 10-19 Times (5) 20-39 Times
   (6) 40+ Times

4. Hard Liquor
   (1) Never (2) Once or Twice (3) 3-9 Times (4) 10-19 Times (5) 20-39 Times
   (6) 40+ Times

5. Coffee or other caffeine (cokes, etc.) Taken together, how many times?
   (1) Never (2) Once or Twice (3) 3-9 Times (4) 10-19 Times (5) 20-39 Times
   (6) 40+ Times

6. Cigarettes
   (1) Never (2) Once or Twice (3) 3-9 Times (4) 10-19 Times (5) 20-39 Times
   (6) 40+ Times

7. Did you use any of the following substances?
   _____ Valium (Librium, Xanax)
   _____ Tranquilizers
   _____ Antiseizure medications (e.g., Dilantin)
   _____ Treatment for Diabetes
   _____ Antibiotics (for viral infections)
   _____ Sleeping pills
   _____ Drugs (please specify):_____
   _____ Other (please specify): _____

B. Perinatal History

8. Did you have toxemia or eclampsia?
   _____ No _____ Yes _____ Don't Know

9. Was there Rh factor incompatibility?
_____ No _____ Yes _____ Don't Know

10. Was (s) he born on schedule?
_____ 8 mos. or earlier _____ Term 8-10 mos. _____ 10 mos. _____ Don't Know

11. What was the duration of the labor?
_____ Under 6 hrs. _____ 7-12 hrs. _____ 13-18 hrs. _____ Over 24 hrs.
_____ Don't Know

12. Were there any complications during labor or during birth?
_____ No _____ Yes _____ Don't Know

13. Was delivery:
Normal? ___ Yes ___ No Breech? ___Yes ___ No Cesarean? ___ Yes ___ No
Forceps? ___ Yes ___ No Induced? ___ Yes ___ No

14. What was the child's birth weight?
___ 2-3 lb. 15 oz ___ 4-5 lb. 15 oz ___ 6-7lb 15 oz ___ 8-9 lb. 15 oz
___ 10-11 lb. 15 oz ___ Don't Know

15. Were there any health problems following birth?
_____ No _____ Yes If yes, specify: _____
_____

16. Were there problems with the infant's responsiveness (alertness)?
_____ No _____ Yes

17. Did the child have any congenital problems?
_____ No _____ Yes

18. Did the child experience any health problems during infancy?
_____ No _____ Yes
If so, what were they? _____

19. Was the child an easy baby? By that I mean did (s)he cry a lot? Did (s)he follow a schedule fairly well?
___ Very Easy ___ Easy ___ Average ___ Difficult ___ Very Difficult

20. How did the baby behave with other people?
_____ More sociable than average _____ Average Sociability _____ More unsociable than average

21. When (s)he wanted something, how strong-willed was (s)he?
_____ Very Insistent _____ Pretty Insistent _____ Average _____ Not very Insistent
_____ Not at all Insistent

22. How would you rate the activity level of the child as an infant/toddler?
_____ Very Active _____ Active _____ Average _____ Less Active _____ Not Active

C. <u>Developmental Milestones</u>

23. At what age did (s)he sit up?
_____ 3-6 mos. _____ 7-12 mos. _____ Over 12 mos. _____ Don't Know

24. At what age did (s)he crawl?
_____ 6-12 mos. _____ 13-18 mos. _____ Over 18 mos. _____ Don't Know

25. At what age did (s)he walk?
_____ Under 1 year _____ 1-2 years _____ 2-3 years _____ Don't Know

26. At what age did (s)he speak single words (other than "mama" or "dada")?
_____ 9-13 mos. _____ 14-18 mos. _____ 19-24 mos. _____ 25-36 mos.
_____ 37-48 mos. _____ Don't Know

27. At what age was (s)he toilet-trained? (Bladder Control)
_____ Under 1 year _____ 1-2 year _____ 2-3 year _____ 3-4 year
_____ Don't Know
Any Problems? _____

28. At what age was (s)he toilet trained? (Bowel Control)
_____ Under 1 year _____ 1-2 year _____ 2-3 year _____ 3-4 year
_____ Don't Know
Any Problems? _____

D. Health

29. How would you describe his/her health?
_____ Very Good _____ Good _____ Fair _____ Poor _____ Very Poor

30. How is his/her hearing?
_____ Good _____ Fair _____ Poor

31. How is his/her vision?
_____ Good _____ Fair _____ Poor

32. How is his/her gross motor coordination?
_____ Good _____ Fair _____ Poor
(Give Example) _____

33. How is his/her fine motor coordination?
_____ Good _____ Fair _____Poor
(Give Example) _____

34. How is his/her speech articulation?
_____ Good _____ Fair _____ Poor

35. Has (s)he had any chronic health problems (e.g. allergies, asthma, diabetes, heart condition)?
_____ No _____ Yes
If yes, please specify: _____
_____

36. When was the onset of any chronic illness?
_____ Birth _____ 0-1 year _____ 1-2 year _____ 2-3 year _____ 3-4 year _____ Over 4 years

37. Which of the following illnesses has the child had?

_____ Mumps _____ Chicken Pox _____ Measles _____ Whooping Cough
_____ Scarlet Fever _____ Pneumonia _____ Encephalitis _____ Otitis Media
_____ Lead Poisoning _____ Seizures _____ Meningitis _____ Hydrocephalus

Other Diseases (specify) _____
_____

38. Has the child had any accidents resulting in the following?

___ Broken Bones ___ Severe Lacerations ___ Head Injury ___ Loss of Consciousness
___ Severe Bruises ___ Stomach Pumped ___ Eye Injury ___ Lost Teeth ___ Sutures

Other (specify): _____
_____

39. How many accidents?

_____ One _____ 2-3 _____ 4-7 _____ 8-12 _____ Over 12

40. Has (s)he ever had surgery for any of the following conditions?

___ Tonsillitis ___ Adenoids ___ Hernia ___ Appendicitis ___ Eye, ear, nose and throat
___ Digestive Disorder ___ Urinary Tract ___ Leg or Arm ___ Burns ___ Other

41. How many times?

_____ Once _____ Twice _____ 3-5 Times _____ 6-8 Times _____ Over 8 Times

42. Has the child ever been physically, emotionally, or sexually abused?

_____ Yes _____ No

Please elaborate _____
_____

43. Please describe your child's general temperament or personality:

_____
_____
_____

44. What are you hoping will happen during the evaluation and/or treatment?

_____
_____
_____

45. List 3 things you would like to change or to see improvement in?

1. _____
2. _____
3. _____

46. List 3 strengths or positive attributes about your child/adolescent.

1. _____
2. _____
3. _____

Thank you.