



DEVELOPMENTAL HISTORY QUESTIONNAIRE

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

DEMOGRAPHICS

Client's Name:

(Last, First):

☐ M

☐ F

D.O.B

(mm/dd/yyyy):

Name of Parents:

Family Heritage:

(e.g. Canadian/Dutch/French)

Marital Status:

☐ Single

☐ Partnered

☐ Married

☐ Separated

☐ Divorced

☐ Widowed

Religious Beliefs:

(e.g. Catholic/Islam/Judaism)

Family Doctor:

REASON FOR REFERRAL

Chief Complaint [These would be the current areas of concern]. Please check any that are appropriate:

Behaviour

- ☐ Physical Aggression
☐ Impulsive type/reactive
☐ Pre-mediated
☐ Property Damage
☐ Impulsive

☐ Verbal Aggression

- ☐ Inattentive
☐ Defiant

☐ Sexual Aggression

- ☐ Hyperactive
☐ Social Skills

Emotional

- ☐ Depressed Mood
☐ Increased Agitation
☐ Appetite Changes/Eating Disorder

- ☐ Suicidal Thoughts
☐ Sleep Changes
☐ Victim of Abuse

- ☐ Quick Emotional Fluctuations
☐ Excessive Changes in Energy
☐ Anxious

Academic

- ☐ Reading Difficulties
☐ Writing Difficulties
☐ Overall Poor Educational Progress

- ☐ Spelling Difficulties
☐ Speech Difficulties
☐ Suspensions/expulsions

- ☐ Math Difficulties
☐ Reading comprehension difficulties
☐ Use of 1:1 EA support in school

Reasoning

☐ Poor Problem Solving

☐ Poor Assessment of Risky Behaviour

Readiness

- ☐ Understands there is a problem and wants help
☐ Understands there is a problem and not overly interested in help
☐ Understands there is a problem and doesn't want help
☐ Doesn't understand that there is a problem

Describe a history of the identified difficulties and any current stressors:

PREVIOUS EVALUATIONS: Please check any that have occurred:

Name of Family Doctor :

When:

Diagnosis:

Name of Pediatrician:

When:

Diagnosis:

Name of Psychiatrist:

When:

Diagnosis:

Name of Psychologist:

When:

Diagnosis:

Name of School Board Psychologist:

When:

Diagnosis:

Other Service Provider:

When:

Diagnosis:

Are there currently any other agencies involved in this client's care? Please check:

☐ Children's Aid Society

☐ Children's Mental Health

☐ Mental Health Clinic

☐ Private Therapist

☐ School Child & Youth Worker

☐ Counseling Services of Belleville

☐ Probation

☐ Court Proceedings

☐ Other

If Involved may these agencies be contacted as part of providing care to this client?

☐ Yes -- Obtain Receive/Release Information sheet

☐ No -- Please explain why

If the child is involved with the Children's Aid Society

Please identify:

Date of apprehension:

Wardship Status:

Name of Children's Service Worker:

Agency:

History of Placement (reasons for changes)

Prenatal Period (Conception to Birth)

What was the mother's age at time of birth?

How many weeks occurred before the mother knew she was pregnant?

Before knowing about the pregnancy did the mother's lifestyle contain any of the following:

The use of prescribed medication

☐ No ☐ Yes – What type of medication and for what reason?

The use of nicotine

☐ No ☐ Yes – If yes, how much was being used?

The use of alcohol

☐ No ☐ Yes – What type and how much was being used?

The use of illicit drugs

☐ No ☐ Yes – What type and how much was being used?

Experienced periods of high stress from relationships, work, community, finances or partner abuse

☐ No ☐ Yes – If yes, please explain

Was the birth of this child ☐ Planned ☐ Unplanned

Comment:

Was the birth of this child ☐ Wanted by both Parents ☐ Unwanted by either Parent ☐ Unwanted, accepted by ☐ mother ☐ father

Comment:

What was the extended family's view of the pregnancy? Check all that apply.

☐ Happy ☐ Supportive ☐ Concerned ☐ Unsupportive ☐ Other:

How did the mother feel physically during the pregnancy?

Did the mother experience any physical or emotional distress during the pregnancy?

☐ No ☐ Yes – Please comment of type of physical, or emotional distress

Did the mother have healthy eating patterns?

☐ No - If no, please explain ☐ Yes

Did the mother take folic acid supplements?

☐ No ☐ Yes

Did the mother take iron supplements?

☐ No ☐ Yes

Did the mother experience any viruses or infections during the pregnancy?

☐ No ☐ Yes – If yes when and what type

Did the mother engage with assistant prenatal care and follow through with one doctor?

☐ No ☐ Yes – If no describe

Were any prescribed medications taken during the pregnancy?

☐ No ☐ Yes - What type of medication and the reason

Did the mother smoke during pregnancy?

☐ No ☐ Yes - When and how much was used.

Any drugs or alcohol taken during the pregnancy?

☐ No ☐ Yes - When, how much and what type was used

Was the baby born full term? (between 38 and 42 weeks) i.e. 40 +/- 2weeks

☐ No - ☐ Yes Please note either premature, or overdue and by how many weeks

Were there complications during the delivery/ How was the labor process?

ex.: non-surgical interventions, forceps, caesarians section

☐ No ☐ Yes - If yes, please comment:

Check all that apply

☐ Short ☐ Long ☐ Easy ☐ Difficult

How much did the baby weigh at birth?

_____ lbs _____ oz or _____ grams

Apgars scores if known _____

Did the baby require medical care resulting in separation from the parents?

☐ No ☐ Yes

If yes, what type of care and for how long:

Infancy (Birth to 2 years)

How would you describe the emotional climate of the home when the baby arrived?

☐ Positive ☐ Concerned ☐ Negative ☐ Comment

Who was the primary caregiver?

☐ Mother ☐ Father ☐ Mother and Father ☐ Other

Please list other caregivers

☐ Mother ☐ Father ☐ Mother and Father ☐ Other

Was the baby recalled to be a good eater, or fussy eater?

☐ Good eater ☐ Fussy Eater ☐ Comment

Was the baby breast fed, or bottle fed?

☐ Breast ☐ Bottle ☐ Comment

How Long?

Any reason why breast or bottle feeding was chosen?

What were the babies' early sleeping habits?

☐ Good ☐ Sleeper ☐ Poor ☐ Sleeper ☐ Comments:

Was the baby "cuddly"?

☐ No ☐ Yes ☐ Comments

Was the baby comfortable with expressing and receiving affection?

☐ No ☐ Yes ☐ Comments

What was the baby's energy level?

☐ Low ☐ Average ☐ High ☐ Comments

Did the baby enjoy exploring the environment?

☐ No ☐ Yes ☐ Comments

Was there anything that the baby appeared to find over-stimulating? (e.g. noise, clothing, people)

☐ No ☐ Yes ☐ Comments

Do you think that your baby began to sit, stand, walk, talk unusually late or early? (if unsure give best number in months).

☐ Low ☐ Average ☐ High ☐ Comments:

Were there periods of high stress for the family in the first two years of life?

☐ No ☐ Yes - If yes, please describe the stress.

Was there any separation between child and mother during the first two years of life?

☐ No ☐ Yes. If yes, please describe why and how old the child was

Was there any separation between child and father during the first two years of life?

☐ No ☐ Yes. If yes, please describe why and how old the child was

When hurt, scared, or sick what was the child's typical reaction?

☐ Calm down by their self ☐ Cry ☐ Yell in the spot where the situation happened ☐ Seek their mother ☐ Seek their father ☐ Comments

Who was considered the primary parent for the child?

☐ Mother ☐ Father ☐ Other

Childhood (age 3 – 11)

Toilet training

At what age did the use of diapers stop during the days?

At what age did the use of diapers stop during the night?

At what age did learning to tie shoes occur?

At what age did riding a bike occur?

Has your child ever been seriously ill? If so what was the illness, age of onset and treatment.

☐ No ☐ Yes ☐ Comments

Any sensitivity to certain foods?

☐ No ☐ Yes ☐ Comments

Any allergies? If so, to what and how was it treated.

☐ No ☐ Yes ☐ Comments

Has your child had any serious accidents or head injuries or seizures?

☐ No ☐ Yes ☐ Comments

Describe temper tantrums.

Any difficulties with speech?

☐ No ☐ Yes ☐ Comments

Any phobias? (Unusual fears?)

☐ No ☐ Yes ☐ Comments

Any unresolved phobias (unusual fears) by age 10?

☐ No ☐ Yes ☐ Comments

Any unusual motor or vocal sounds? (Tics?)

☐ No ☐ Yes ☐ Comments

Please comment on the following areas associated with childhood temperament

Activity: Activity refers to the child's physical energy. Please comment

Regularity: Regularity, also known as Rhythmicity, refers to the level of predictability in a child's biological functions, such as waking, becoming tired, hunger, and bowel movement. Please comment

Initial reaction: Initial reaction is also known as Approach or Withdrawal. This refers to how the child responds (whether positively or negatively) to new people or environments. Please comment

Adaptability: Adaptability refers to how long it takes the child to adjust to change over time (as opposed to an initial reaction). Please comment

Intensity: Intensity refers to the energy level of a positive or negative response. Does the child react intensely to a situation, or does the child respond in a calm and quiet manner? Please comment

A more intense child may jump up and down screaming with excitement, whereas a mild mannered child may smile

Mood: Mood refers to the child's general tendency towards a happy or unhappy demeanor. Please comment

Distractibility: Distractibility refers to the child's tendency to be sidetracked by other things going on around them. Please comment

Persistence and attention span: Persistence and attention span refer to the child's length of time on a task and ability to stay with the task through frustrations. Please comment

Sensitivity: Sensitivity refers to how easily a child is disturbed by changes in the environment. This is also called sensory threshold or threshold of responsiveness. Is the child bothered by external stimuli like noises, textures, or lights, or does the child seem to ignore them. Please comment

How would you describe the mother and fathers parenting style?

Mother ☐ Passive ☐ Assertive ☐ Demanding ☐ Aggressive ☐ Other:

Father ☐ Passive ☐ Assertive ☐ Demanding ☐ Aggressive ☐ Other:

What was the child's reaction to discipline like?

☐ Accepting ☐ Passive ☐ Defiant ☐ Aggressive Other

Any tendencies for the child to be excessively independent or dependent?

☐ Dependent ☐ Independent ☐ Mix

Did the family experience periods of high stress during the childhood period?

☐ No ☐ Yes. If yes, what type of stress and what was the child's reaction to the stress

Was there any disruption in the parental relationship by separation, or divorce?

Was the child exposed to any form of domestic violence?

☐ No ☐ Yes If yes, please comment:

During childhood where any of these features present (Please check all that apply)

<input type="checkbox"/> Excessive Clingy	<input type="checkbox"/> Periods of being unresponsive	<input type="checkbox"/> Inability to self-sooth
<input type="checkbox"/> Seeking comfort and then aggressive behaviour	<input type="checkbox"/> Inability to deal with stress/separation	

Was medical or clinical assistance provided to help development during childhood?

☐ No ☐ Yes If yes, who provided the assistance and was it effective

Was medication prescribed to help development during childhood?

☐ No ☐ Yes If yes, what type of medication and dose (starting with the first) and their response to the medication

<u>TYPE</u>	<u>DOSE</u>	<u>REPONSE</u>

Was any herbal or non-medical supplement used to help development during childhood?

☐ No ☐ Yes If yes, what was the supplement and was it effective

Adolescence (12-18 years) (Skip if child is currently younger - go to Family Section)

When did puberty start?

☐ 10 yrs ☐ 11 yrs ☐ 12 yr ☐ 13 yrs ☐ 14 yrs

What was the child's reaction to the physical changes of puberty?

Comments

Please rate these skills for your child during this period.

Area	1(Very Poor)	2(Poor)	3(Adequate)	4(Well)	5 (Very Well)
Could handle feelings of sadness	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle feelings of anxiety	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle feelings of anger	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle being excited	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle sexual feeling	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to show impulse control	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to develop friendships	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to maintain friendships	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to accept parental redirection	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to pick a positive peer group	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could hold his/her beliefs despite beliefs of friends	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

Does the child experience mood swings beyond what is considered normal in adolescence?

☐ No ☐ Yes if yes please comment

Has there been any problem with getting to sleep at night?

☐ No ☐ Yes If yes, how long between going to bed and falling asleep

Have there been any problems with staying asleep at night?

☐ No ☐ Yes if yes, do they ☐ sleep talk ☐ sleep walk ☐ have nightmares ☐ snore ☐ awake repetitively? ☐ Comment

Have there been any problems with awaking early in the morning and not being able to get back to sleep?

☐ No ☐ Yes

Is the child still tired in the morning despite sleeping?

☐ No ☐ Yes ☐

Has the child ever not required sleep and stayed up for more than 24 hours?

☐ No ☐ Yes If yes, please describe their behavior around that time

If yes, please describe their behavior around that time?

☐ No ☐ Yes If no, please comment?

Is there any concern about the child's weight?

☐ No ☐ Yes If yes, please comment on underweight, or overweight.

If female is birth control prescribed, or if male is he aware of and have access to condoms?

☐ No ☐ Yes ☐ Comments

Has the child been sexually active?

☐ No ☐ Yes If yes, when did this start ☐ I Don't Know

Sexual Abuser/Abuse or victim?

☐ No ☐ Yes If yes, when did this start ☐ I Don't Know

Has the child been sexually mistreated?

☐ No ☐ Yes If yes, when did this start ☐ I Don't Know

Has the child sexually mistreated someone?

☐ No ☐ Yes If yes, when did this start ☐ I Don't Know

Has the child experimented with nicotine?

☐ No ☐ Yes If yes, when did this start and how much is used per day.

Has the child used alcohol, or drugs?

☐ No ☐ I Don't Know ☐ Yes If yes when did this start, what has been tried and how much is believed to be used

Has the child shown behavior that has resulted in contact with the police?

☐ No ☐ Yes If yes, what was the behavior and what did the police do.

Has the child ever run away from home?

☐ No ☐ Yes If yes, what was the trigger, where did they go and how long were they gone.

Has the child demonstrated any unusual interests, or fascinations?

☐ No ☐ Yes If yes, please comment:

Has the child reported the experience of any unusual sight, sounds, or physical feelings?

☐ No ☐ Yes If yes, please comment:

Has the child demonstrated periods of being unable to describe, or report why they engaged in disruptive behaviour?

☐ No ☐ Yes If yes, please comment:

Has the child shown any obsessive tendencies with: (check all that apply)

☐ Television ☐ Video Games ☐ Music ☐ Internet ☐ Sexual material ☐ Obsessed about another person ☐ Drugs ☐ Violence

Please comment:

Has the child ever displayed any reckless behavior that concerns you?

☐ No ☐ Yes if yes, please comment:

Has any special gifts or talents emerge for your child during this period?

☐ No ☐ Yes Please Comment:

Did the family experience periods of high stress during the adolescent period?

☐ No ☐ Yes If yes, what type of stress and what was the child's reaction to the stress.

Was there any disruption in the parental relationship by separation, or divorce?

☐ No ☐ Yes If yes, how old was the child, what was their reaction and how was care provided for the child.

Was medical or clinical assistance provided to help development during adolescence?

☐ No ☐ Yes If yes, who provided the assistance and was it effective.

Was medication prescribed to help development during adolescence?

☐ No ☐ Yes If yes, what type of medication and dose (starting with the first) and their reaction to the medication

TYPE

DOSE

REPONSE

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Was any herbal or non-medical supplement used to help development during adolescence?

☐ No ☐ Yes If yes, what was the supplement and was it effective.

Family

Who are the current people living in the house and the relationship to your child?

Does your child have any brothers or sisters?

How old?

How do they get along?

Biological Mother - How would you describe yourself? What is your level of education? Any specific difficulties in school or specific likes or dislikes?

Biological Father - How would you describe yourself? What is your level of Education?

Any specific difficulties in school or specific likes or dislikes?

Step Parent - How would you describe yourself? What is your level of education?

Any specific difficulties in school or specific likes or dislikes?

Any family history [any biological relatives] of medical or psychological difficulties? Please check all that apply.

Issue	Who	Any known or unsuccessful treatments
<input type="radio"/> Depression		
<input type="radio"/> Anxiety (Phobias, OCD, Social)		
<input type="radio"/> Bipolar Disorder		
<input type="radio"/> ADHD		
<input type="radio"/> Suicidal Thoughts/suicides		
<input type="radio"/> Homicidal Thoughts/Homicides committed		
<input type="radio"/> Alcohol Misuse		
<input type="radio"/> Drug Use		
<input type="radio"/> Developmental Disabilities		
<input type="radio"/> Learning Disabilities		
<input type="radio"/> Criminal Charges/Jail time		
<input type="radio"/> Personality Disorders		
<input type="radio"/> Any Social/Emotional Issues		
<input type="radio"/> Any Medical conditions – esp. diabetes, obesity, heart disease, cancer		
<input type="radio"/> Sexual problems		
<input type="radio"/> Financial problems		
<input type="radio"/> Problems with driving		
<input type="radio"/> History of sudden deaths		

Any other family issues viewed as important

Comment

Educational

What was the earliest grade your child attended in school, including nursery school?
How old was your child?

☐ Nursery School ☐ 3 yrs Jr. Kindergarten ☐ 4 yrs Sr. Kindergarten ☐ 5 yrs Grade 1 - 6 yrs

How did the child react with the separation from home?

☐ Positive ☐ Negative ☐ Comments

Have any academic concerns developed? If so what and when?

☐ Reading ☐ Spelling ☐ Math ☐ Writing ☐ Comprehension ☐ other

Identified in: ☐ JK ☐ SK Grade ☐ 1-2 Grade ☐ 3-4 ☐ Grade 5-6 ☐ Grade 7-8

Has your child had any behaviour problems at school? If so what and when did they start?

☐ Physical ☐ Verbal Sexual ☐ Other

Identified in: ☐ JK ☐ SK Grade ☐ 1-2 Grade ☐ 3-4 ☐ Grade 5-6 ☐ Grade 7-8

What does your child's report usually look like?

☐ Above Average ☐ Average ☐ Below Average ☐ Barely Passing ☐ Failing

Does the client receive any form of special assistance at school or outside of school to help their learning?

Does the client have an Educational Ministry Identification or Individual Education Plan? If identified, what is the identification? If on an IEP what is the focus.

<input type="checkbox"/> No IEP	<input type="checkbox"/> Communicative Learning Disability	<input type="checkbox"/> Mild Intellect Impairment	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Speech & Language	<input type="checkbox"/> Medical	<input type="checkbox"/> Behavioural	<input type="checkbox"/> Multiple

Please comment on focus of IEP:

What is their current school and grade?

Any current academic issues of importance?

☐ Comments

Has the child vocalized goals regarding their education?

☐ Comments

Employment (If not of age, Skip to Medical Section)

Has there been a success part-time job experience?

☐ No ☐ Yes ☐ Comments

Has there been success full-time job experienced?

☐ No ☐ Yes ☐ Comments

Are there certain skills that stand in the way of successful employment?

☐ Reading ☐ Spelling ☐ Math ☐ Writing ☐ Comprehension ☐ Social Skills ☐ Problems with Authority

Are there specific employment goals that have been stated?

☐ Comment

Medical

Has a recent physical exam been completed?

☐ No ☐ Yes ☐ Comments

Has recent blood work been completed?

☐ No ☐ Yes ☐ Comments

Have recent hearing and vision tests been completed?

Are glasses prescribed? ☐ Yes ☐ No

☐ Vision: Yes (fine) No Uses or needs glasses

☐ Hearing: Yes (fine) No Identified problems

Any known specific allergies to medications?

☐ No ☐ Yes ☐ Comments ☐ Comment

Any known illness at the time of completing this form?

☐ No ☐ Yes ☐ Comments ☐ Comment

Prescription medication at the time of completing this form.

Type

Dose

Believed Effectiveness

Any over the counter medications taken at the time of completing this form.

Type

Dose

Believed Effectiveness

Type	Dose	Believed Effectiveness
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctors involved in providing care at the time of this consultation

☐ Family Doctor:

☐ Psychiatrist:

☐ Pediatrician

☐ Counselor:

☐ Other

Who would you like information involved in your care released to?

☐ Yes – Obtain Receive/Release Information sheet

☐ No – Please explain why

Developmental History Completed by: _____

Date of Completion: _____

Please fax this document to our office (613)967-3998 prior to your first appointment.

Thank you for completing this information it will be use to provide context to any other interview, or assessment data that is generated to develop appropriate treatment plans.

Date received: _____