



Samaritan Counseling Center

1803 Oregon Pike, Lancaster, PA 17601 • 717-560-9969

DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about your child and your family. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at the time of your child's appointment.

Today's date: _____

Child's Name	Child's Date of Birth	Age	Grade	Child's Soc. Sec. #
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Person Completing Form	Your Relationship to Child
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Mother's Name	Date of Birth	Work Phone	Home Phone	Cell Phone
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Address	City	State	Zip
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Father's Name	Date of Birth	Work Phone	Home Phone	Cell Phone
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Address	City	State	Zip
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Is this your biological, adopted, step, foster, other _____ child?

Are the child's parents married? No Yes
If no, is there a custody agreement? No Yes – Please provide at first session.

In whose physical custody is this child? Mother Father Both Other

In whose legal custody is this child? Mother Father Both Other

If other, Name	Work Phone	Home Phone	Cell Phone
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Address	City	State	Zip
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Health Insurance Company: _____

ID Number: _____ Group Number: _____

Name of and Your Relationship to the Policy Holder: _____

Date of Birth of the Policy Holder: _____ Employer of the Policy Holder: _____

Who Will Be Responsible For Payment? _____

Who Referred You To Samaritan Center? _____

What are your concerns about this child? What are the difficulties/problems that cause you to seek help at this time? _____

What has worked/has not worked in attempts to resolve this issue(s)? _____

- Do you see this child as:
- hyperactive No Yes
 - having problems with attention and concentration? No Yes
 - forgetful No Yes
 - frequently losing things No Yes
 - acting without thinking No Yes
 - engaging in reckless behavior No Yes
 - disorganized No Yes

CHILD'S DEVELOPMENTAL HISTORY

Pregnancy

Mother's age at the time of pregnancy with this child _____ Length of pregnancy in months (or weeks) if known _____

Were any medications used during pregnancy? No Yes
If yes, please specify: _____

Did the mother smoke cigarettes during this pregnancy? If yes, please specify average number of cigarettes per day. No Yes

Did the mother drink alcohol during this pregnancy? If yes, what type of alcohol and how much was consumed per day? No Yes

Did the mother use any type of drugs during this pregnancy? If yes, what type of drugs and how much were used per day? No Yes

Pregnancy complications (check all those that apply):

- bleeding high blood pressure toxemia
- infections diabetes other, please explain: _____

Delivery

Type of labor: spontaneous induced due to _____

Type of birth delivery: normal breech Cesarean section

Duration of labor: _____ hours

Check all those that apply:

- forceps used baby born in some type of danger
- hemorrhage/excessive blood loss (e.g., cord was around the baby's neck,
- multiple birth heart rate problems, etc.) Please specify: _____

Were there any problems with labor and/or delivery? No Yes (please explain): _____

Perinatal History

Baby's weight at birth: _____ pounds _____ ounces

Baby's length at birth: _____ inches

Check those that apply:

- jaundice
- incubator
- problems sucking
- baby on heart monitor
- blood transfusions (baby)
- problems eating/digestion
- problems breathing
- baby given oxygen
- Other, please explain: _____

Any other problems or comments regarding this child when he/she was a newborn? If yes, please specify.

- No
- Yes

Infancy and Early Childhood

Check all that apply. If yes, please specify.

- Colicky No Yes _____
- Feeding problems No Yes _____
- Sleeping problems No Yes _____
- Restless No Yes _____
- Active No Yes _____
- Did not enjoy cuddling No Yes _____
- Excessive fearfulness No Yes _____
- Excessive shyness No Yes _____
- Strong reluctance to separate from mother No Yes _____
- Headbanging No Yes _____
- Accident prone No Yes _____
- Uncoordinated No Yes _____
- Are there other problems or comments regarding this child's infancy and early childhood development? If so, please explain: No Yes

Child's approximate age when she/he began:

walking _____ months

talking (single words) _____ months

talking (short sentences--2+ words) _____ years

toilet training: daytime _____ years nighttime _____ years

Does this child have wetting accidents in bed currently? (day/night?) No Yes

Does this child have soiling accidents currently? (day/night) No Yes

Did this child previously have a problem with wetting or soiling? (day/night?) If yes, please explain. No Yes

Overall, do you feel this child developed at a slow rate normal rate rapid rate?
Please explain:

Childhood Diseases

Check all those that apply. In the extra space provided, please describe the condition, and specify the type of treatment she/he received and if this child continues to receive treatment for the condition.

asthma No Yes _____

lead poisoning No Yes _____

cerebral palsy No Yes _____

heart problem No Yes _____

vision difficulties No Yes _____

hearing difficulties No Yes _____

Any other special health considerations? Please explain. No Yes

Has this child ever been taken to the Emergency Room? No Yes; at age _____

Reason _____

Has this child undergone any type of surgery? No Yes; at age _____

Type of Surgery _____

Was this child hospitalized for any other type of illness thus far not covered? No Yes; at age _____

Reason _____

Has this child suffered any type of head injuries? No Yes; at age _____

With loss of consciousness? _____

Has this child experienced any seizures? No Yes; at age _____

Cause of seizures _____

What was the highest fever this child has had? What was the nature of the illness associated with this fever? _____

Does this child suffer from allergies? No Yes; type of allergy _____

Has this child suffered from ear infections? No Yes

The types of medical treatment this child has received for his/her infections (e.g., antibiotics, antihistamines, tubes). _____

Total number of ear infections (approximately) _____

Longest duration of any ear infection _____

CHILD'S PRESENT MEDICAL STATUS

Child Under Medical Care of (Pediatrician) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Have you notified the child's physician of your appointment here? No Yes

Have you discussed this child's problems with the physician? No Yes

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? No Yes; please explain _____

Is this child taking any type of medication at this time? No Yes; please list below :

Name of Medication	Dosage	Duration	Reason

Has this child ever done any of the following?

- Play with fire No Yes
- Suck thumb past the normal age No Yes
- Walk in sleep frequently No Yes
- Been cruel to animals No Yes

Has this child experienced any serious traumatic events? No Yes. If so, please explain: _____

Has this child ever been physically abused? No Yes. If so, please explain: _____

Has this child ever been sexually abused? No Yes. If so, please explain: _____

Is this child *currently* involved in any type of professional mental health treatment (e.g., psychotherapy, family counseling sessions, etc.)? No Yes

Has this child ever been involved in any type of professional mental health treatment? No Yes

Name of therapist	Age of this child at the time of treatment	Duration	Purpose of therapy

Do any other family members suffer from some type of psychological emotional, learning problem, and/or disorder? If yes, please list below. No Yes

Relationship to Child	Current Age	Type of Problem	Severity? e.g. mild, severe	Type of Treatment

CHILD'S EDUCATIONAL PLACEMENT

Name of School	School District	Grade

Type of Classroom Placement (e.g., regular, ED, LD, Resource Room, etc.)

Check all those official school classifications which apply to this child:

- Learning Disabled
- Emotionally Disturbed
- Other _____
- Visually Impaired
- Hearing Impaired
- Mentally Retarded/Intellectually Limited
- Physically Handicapped

Did this child attend any type of preschool program? No Yes
 If yes, what type of program and at what age did she/he begin, and the frequency of attendance (e.g., nursery school: age 4, 2X/week/2hr. session).

Did this child experience any problems in preschool? No Yes
 If yes, please describe:

Generally, what are this child's grades? A/B B/C C/D D/F

Did this child repeat any grades? No Yes; grade(s) _____

Did this child fail any subjects? No Yes; which subject(s) _____

Does this child currently receive any special education services? No Yes; type _____
 (e.g., self-contained class, resource room, reading or math lab, etc.).

Hours/day or week _____

MOTHER'S FAMILY HISTORY

Name: _____ Birth Date: _____ Age: _____

Birth Place: _____ Religion/Church: _____

Highest Grade Completed: _____ Highest Degree: _____

Have you experienced difficulties with learning? No Yes; please describe _____

Any mental health problems for which you have received treatment? No Yes
If yes, please describe the problem and the treatment received. _____

Any medical problems? No Yes
If yes, please specify. _____

Do you smoke cigarettes? No Yes; cigarettes/day _____

Do you currently drink alcohol? No Yes; type of alcohol _____
Number of drinks/day/week/month _____

Do you currently use any type of drugs? No Yes; type of drugs _____
Frequency _____

Occupation _____ Current Place of Employment _____

During which years of your child's life have you worked? _____

Current marital status: Married _____ years
Separated _____ years
Divorced _____ years
Widowed _____ years
Single _____ years
Other (please explain): _____

Marital History: How many times been married (including current)? _____

FATHER'S FAMILY HISTORY

Name: _____ Birth Date: _____ Age: _____

Birth Place: _____ Religion/Church: _____

Highest Grade Completed: _____ Highest Degree: _____

Have you experienced difficulties with learning? No Yes; please describe _____

Any mental health problems for which you have received treatment No Yes
If yes, please describe the problem and the treatment received. _____

Any medical problems? No Yes. If yes, please specify. _____

Do you smoke cigarettes? No Yes; cigarettes/day _____

Do you currently drink alcohol? No Yes; type of alcohol _____
Number of drinks/day/week/month _____

Do you currently use any type of drugs? No Yes; type of drugs _____
Frequency _____

Occupation _____ Current Place of Employment _____

During which years of your child's life have you worked? _____

Current marital status: Married _____ years
Separated _____ years
Divorced _____ years
Widowed _____ years
Single _____ years
Other (please explain): _____

Marital History: How many times been married (including current)? _____

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

Please use this space for any additional information/comments you wish to share with us about your child or family. _____

