Triangle Center for Behavioral Health
Lisa Senatore, Ph.D., PLLC
Developmental Questionnaire

Child's Legal Name:_____ Today's Date:___/___/___

Child's Preferred Name: _____ Child's Age:_____ Child's Birthdate:___/___/____

Child's sex assigned at birth:_____ Child's gender identity: _____ Preferred Pronouns: _____

Address:_____

City:_____ State/Province:_____ Zip/Postal Code:_____

How long has child lived at this address?_____

Current School: _____ Current Grade:_____

Person completing this form:_____ Relation to Child:_____

Please briefly state your concerns that led to you to arrange an evaluation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Who referred you here?

Name:_____ Email Address:_____

Demographic Information:

Parent/Legal Guardian's Name:_____ Age:_____

Relationship to the Child: (mother, father, step-parent, grandparent, etc.)_____

Biological Parent? ☐ Yes ☐ No (name/relationship of biological parent: _____)

Employer/Type of Work:_____ Education:_____

Work/Mobile Phone:_____ Home Phone:_____

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text reminders? ☐ Yes ☐ No

Email Address: _____ ☐ Check if this person is primary contact

Parent/Legal Guardian's Name:_____ Age:_____

Biological Parent? ☐ Yes ☐ No (name of biological parent: _____)

Relationship to the Child: (mother, father, step-parent, grandparent, etc.)_____

Employer/Type of Work:_____ Education:_____

Work/Mobile Phone:_____ Home Phone:_____

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text reminders? ☐ Yes ☐ No

Email Address: _____ ☐ Check if this person is primary contact

Other Caregiver's Name:_____ Age:_____

Relationship to the Child: (mother, father, step-parent, grandparent, etc.)_____

Biological Parent? ☐ Yes ☐ No (name/relationship of biological parent: _____)

Employer/Type of Work:_____ Education:_____

Work/Mobile Phone:_____ Home Phone:_____

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text reminders? ☐ Yes ☐ No

Email Address: _____ ☐ Check if this person is primary contact

Who lives in the home with the child?:

Name/Age/Relation:_____ Name/Age/Relation:_____

Name/Age/Relation:_____ Name/Age/Relation:_____

Name/Age/Relation:_____ Name/Age/Relation:_____

Siblings living outside of the home?:

Name/Age/Relation:_____ Name/Age/Relation:_____

Name/Age/Relation:_____ Name/Age/Relation:_____

If parents/legal guardians are divorced or legally separated:

Date (s) of legal separation/divorce: _____

Who has legal custody for medical decision making?**

☐ Parent Name: _____ ☐ Parent Name: _____

☐ Joint Custody ☐ Neither (explain): _____

What is the physical custody schedule currently:_____

**Please provide copy of portion of court order or separation agreement related to legal custody.

***Please note: All parents with legal custody must sign the Practice Agreement prior to testing.

Is this child adopted? ☐ No ☐ Yes, please describe the circumstances of the adoption:_____

_____

_____

Is more than one language spoken in your home? ☐ No ☐ Yes, what is the primary language spoken in your home?: _____

Pregnancy: ***If don't know pregnancy history due to adoption, please check here:*** _____

Was the pregnancy with this child under a doctor's care? ☐ No ☐ Yes ☐ Don't know

Check any that apply for this pregnancy:	Describe/Treatment
☐ Artificial Insemination/Donor	_____
☐ Anemia	_____
☐ Elevated Blood Pressure	_____
☐ Toxemia	_____
☐ Swollen Extremities	_____
☐ Kidney Disease	_____
☐ Bleeding/ Threatened Miscarriage	_____
☐ Measles/German Measles	_____
☐ Flu	_____
☐ Strep Throat	_____
☐ Other Virus/Illness/Injury	_____
☐ Abnormal Nausea or Vomiting	_____

☐ Medication(s) Taken _____

☐ Emotional Problems/Distress _____

☐ Premature Labor _____

☐ Smoked During Pregnancy _____

☐ Drank Alcohol During Pregnancy _____

Birth History: ***If don't know birth history due to adoption, please check here:*** ____

Mother's age at the time of child's birth: _____ Father's age at the time of child's birth: _____

Child's birth weight? ____lbs.____oz. Was birth a multiple?: ☐ No ☐ Yes, how many:_____

Was birth complicated by: Describe

☐ Prematurity _____

☐ Unplanned Induced Labor _____

☐ Breech presentation _____

☐ Cesarean section _____

☐ Unusual anesthesia _____

☐ Other _____

Following birth, were there complications related to:

☐ Breathing problems _____

☐ Need for oxygen _____

☐ Blue color _____

☐ Meconium _____

☐ Cord around the neck _____

☐ Jaudice/yellow color _____

☐ Feeding problems _____

☐ Maternal health _____

Did these complications result in an extended hospital stay? ☐ No ☐ Yes, how long:_____

Developmental History:

Motor Development (Sitting, Walking) ☐ Normal ☐ Fast ☐ Slow

Speech and Language ☐ Normal ☐ Fast ☐ Slow

Self-help Skills (dressing, toileting, hygiene)	☐ Normal	☐ Fast	☐ Slow
Handedness	☐ Right	☐ Left	☐ Both
Bowel Trained:	☐ Normal	☐ Fast	☐ Slow
Bladder Trained:	☐ Normal	☐ Fast	☐ Slow
Eating Behavior:	☐Picky	☐Average	☐ Over eats
Sleeping Behavior	☐ Normal	☐ More	☐ Less

Temperament (Infancy, Toddler, Preschool): Check all that apply:

Activity:	Emotional:	Interpersonal:
☐ Rocking/Head banging	☐ Shy or timid	☐ Affectionate
☐ Impulsive	☐ Fearful	☐ Distant/Hard to engage
☐ Daredevil	☐ Cautious	☐ More interested in things than in people
☐ Temper outbursts	☐ Happy	☐ Slow to warm up
☐ Overactive	☐ Curious	☐ Aggressive
☐ Into everything	☐ Irritable	☐ Clingy
☐ Easy to manage	☐ Sad	☐ Stubborn
☐ Hard on belongings		☐ Independent

Medical History

Has your child had any of the following?

	No	Yes	Date/Age/Description
Measles	☐	☐	_____
Mumps	☐	☐	_____
Rubella	☐	☐	_____
Migraine	☐	☐	_____
Severe Abdominal Pain	☐	☐	_____
Cancer	☐	☐	_____
Chicken Pox	☐	☐	_____
Whooping Cough	☐	☐	_____
RSV	☐	☐	_____
Severe Flu	☐	☐	_____
Strep Throat	☐	☐	_____
Meningitis/ Encephalitis	☐	☐	_____
Constipation	☐	☐	_____

Urinary Tract Infections	☐	☐	_____
Abscessed Ears	☐	☐	_____
Tubes in Ears	☐	☐	_____
Allergies	☐	☐	_____
Asthma	☐	☐	_____
Seizures	☐	☐	_____
Head Injuries	☐	☐	_____
Other Injuries	☐	☐	_____
Hospitalizations	☐	☐	_____
Hearing Problems	☐	☐	_____
Vision Problems	☐	☐	_____
Other	☐	☐	_____

Does your child currently take medication for a medical illness? ☐ No ☐ Yes

If yes, please describe: _____

_____

Does your child have known allergies to any medications? _____

_____

Family Medical/Psychiatric History:

Have any of your child's **biological relatives** had physical health problems?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: _____

_____

_____

_____

_____

Have any of your child's **biological relatives** had mental health issues?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: _____

_____

_____

_____

_____

Outside of biological relatives, are there **any other people with whom the child has significant contact** who have medical or psychiatric issues?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: _____

_____

_____

_____

_____

Academic Information:

Current School: _____ Current Teacher/Grade: _____

Current Teacher's Email: _____

School's Address/Phone: _____

_____

Type of school: ☐ Public ☐ Private ☐ Other _____

List ALL previous schools and grades attended	Academic Struggles?		Behavioral Struggles?	
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No

Repeated Grade?: ☐ No ☐ Yes: reasons: _____

_____

_____

Skipped Grade?: ☐ No ☐ Yes: reasons: _____

_____

_____

Behavior Consequences?

In-school Suspensions: ☐ No ☐ Yes: reasons: _____

Out-school Suspensions: ☐ No ☐ Yes: reasons:_____

Expulsions? ☐ No ☐ Yes: reasons:_____

How have your child's teachers generally described your child's behavior at school?_____

_____

_____

_____

Learning Difficulties/Strengths? ☐ No ☐ Yes (describe):

Has testing been completed? ☐ No ☐ Yes: results? (Please provide copies if possible):_____

_____

_____

Does your child have an IEP/504 Plan/accommodations: ☐ No ☐ Yes: details:_____

_____

Does your child have a DEP/gifted services: ☐ No ☐ Yes: details:_____

_____

What does your child like most/dislike most at school?_____

_____

_____

Which of the following problems, if any, does this child have in school?

☐ Does not do homework	☐ Forgets assignments	☐ Below Average reading skills
☐ Fails to check work	☐ Many careless errors	☐ Below Average spelling
☐ Incomplete homework	☐ Incomplete classroom work	☐ Below Average math
☐ Not remaining seated	☐ Disorganization	☐ Below Average written language
☐ Inattention in class	☐ Talks excessively	☐ Below Average handwriting
☐ Distraction	☐ Anxiety	☐ Excessive time to complete work

Further comments on homework, academic functions:_____

_____

Psychosocial Functioning:

Which of the following, if any, describe(s) this child's interactions with peers?

☐ No friends	☐ Average number of friends	☐ Trouble keeping friends
☐ Few Friends	☐ Socially comfortable	☐ Trouble making new friends
☐ Controlling	☐ Aggressive	☐ Bullying
☐ Excessively shy	☐ Overall social	☐ Socially awkward

Extracurricular/Group Activities:

Further comments on peer functioning:

Therapy History:

Has your child ever received talk therapy? ☐ No ☐ Yes
If no, please go to medication questions.

If yes, please complete the following:

Has your child received Cognitive Behavioral Therapy (CBT)? ☐ No ☐ Yes ☐ Don't know

If yes, did it include assigned "homework"? ☐ No ☐ Yes ☐ Don't know

Provider	Reason for treatment	Length of treatment	Outcome

Has your child ever taken psychiatric medication? ☐ No ☐ Yes

If yes, please complete the following:

Medication	Dosage	Dates of Use	Prescriber	Benefits	Side Effects

Is there anything else you would like us to know about this child before we meet?

_____

_____

_____