SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

The information gathered on this form can be used when writing a Social/Developmental History.

I. GENERAL INFORMATION

Child's full name_____ Grade_____ Age_____ DOB_____

Current Address: _____ How long at this address? _____

Person providing information: _____ Relationship to child_____

Who does child live with: □ both parents □ mother □ father □ other (specify) _____

Biological father_____ Occupation_____ Years education: _____
Father's home phone_____ Work #_____ Cell #_____

Biological mother_____ Occupation_____ Years education: _____
Mother's home phone _____Work #_____ Cell #_____

□ N/A Guardian's name_____ Occupation _____Years education_____
Guardian's home phone _____ Work #_____Cell #_____

Please list all people in child's immediate family:

Name	Relationship to child	Age / Grade	Living in house?

Please list all other *non-family* members who live in household:

Name	Relationship to child/family	How long has lived in household?

Language(s) spoken at home _____ Primary Language at home_____

Please list all locations (city, state) that your child has lived:

1. Birthplace _____ Moved at age/grade _____
2. _____ Moved at age/grade _____
3. _____ Moved at age/grade _____
4. _____ Moved at age/grade _____

Are biological parents of child currently: □ married □ separated □divorced □ never married

- If separated or divorced, who has *legal* custody? □ mother □ father □ other (specify): _____
- If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

Are there other adults who have a *significant* part in raising your child? □Yes □No
If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.)_____

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc)

_____
_____

What do you feel are your child's...
Strengths_____
Weaknesses _____

Briefly describe your concerns for your child.

_____
_____
_____

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is child your: □ biological child □ adopted child □ foster child □ other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used: _____

_____

Pregnancy lasted _____weeks / months Child's birth weight: _____pounds _____ounces

APGAR score ...at 1 minute_____ ...at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No
If No, explain why: _____

Please check the conditions below that describe the health of the child and mother during...

Mother's Pregnancy
- □ No Complications
- □ Blackouts
- □ Falls
- □ Physical Injury
- □ Blackouts
- □ Excessive Bleeding
- □ Hypertension
- □ Diabetes
- □ Emotional Stress
- □ Toxemia
- □ Alcohol/Drug Use
- □ Use of Tobacco

Child's Delivery
- □ Normal
- □ Induced Labor
- □ C-Section
- □ Breech birth
- □ Unusually long labor (>12 hrs)
- □ Premature # of weeks_____
- □ Overdue # of weeks_____
- □ Other Problem (Specify) _____

_____
_____
_____
_____

Child's Condition at Birth
- □ Normal / No problems
- □ Lack of Oxygen
- □ Breathing Problem
- □ Birth Injury/Defect:
- □ Jaundice
- □ Newborn ICU # of days _____
- □ Other Problem (Specify) _____

_____
_____
_____
_____
_____

B. Health

Describe the state of your child's current health: □ Excellent □ Good □ Fair □ Poor

Is your child currently taking any medication? □Yes □ No
If yes, please list medications and uses: _____

Has your child ever been identified as having a disability? □Yes □ No
If so, by whom, what age, & what disability? _____

Has your child ever received psychological counseling? □Yes □ No
If "yes," by whom (professional/agency) and when: _____

Has your child had any of the following?	Please describe and give details, dates, and/or age onset
□ Serious Illnesses	
□ Head Injuries	
□ Seizures or convulsions	
□ Surgery/Hospitalization	
□ History of Ear Infections	
□ Allergies and/or Asthma	
□ Vision Problems	
□ Hearing Problems	
□ Frequent Nightmares and/or Bedwetting	
□ Other health problem:	

Is there a *family history* for the following problems?	*Biological* family member with the history … (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
□ Learning Difficulties (reading, math, writing, spelling)	
□ Speech or Language problem (articulation, stuttering, etc.)	
□ Developmental Disorder (such as Autism, Aspergers, etc.)	
□ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
□ Mental Retardation	
□ School Failure (failing grades, dropout, etc)	
□ Drug or Alcohol Addiction	

C. Development

Please indicate the age or age range when your child performed the following milestones:

Milestone:	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Sat up without help							
Crawled							
Walked alone							
Walked up stairs							
Spoke first words							
Spoke short phrases							
Spoke sentences							
Fully bladder trained							
Fully bowel trained							
Stayed dry all night							

III. BEHAVIOR

A. Behavior in Infancy

During you child's first *few years of life*, were any of the following present to *significant* degree?

- ☐ Did not enjoy cuddling
- ☐ Was not easily calmed by being held or stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Difficult nursing
- ☐ Poor eye contact/did not turn towards caregivers
- ☐ Did not respond to name or speech of caregivers
- ☐ Fascination with certain objects
- ☐ Constantly into everything
- ☐ Frequent head banging

* If checked any above, please describe_____

_____

B. Child's Early Temperament: (*Toddler through five years of age*)

❖Activity Level – How active has your child been from an early age?

_____

_____

❖Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks?

_____

_____

❖Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way?

_____

_____

❖Approach/Withdrawal – How well was your child able to respond to new things (i e , new places, people, food, etc.)?

_____

_____

❖Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.?

_____

_____

❖Mood -- What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament?

_____

_____

❖Regularity -- How predictable was your child's patterns of activity level, sleep, appetite, etc.?

_____

_____

Prior to age six, did your child have more difficulty than other children his/her age....

- ☐ Sitting still at meal time
- ☐ Paying attention when read to
- ☐ Throwing a ball
- ☐ Catching a ball
- ☐ Buttoning & Zipping
- ☐ Holding crayon or pencil
- ☐ Accidentally dropping things
- ☐ Staying focused on TV, movies, or video games
- ☐ Waiting for turn at play
- ☐ Knowing left and right
- ☐ Acting without thinking
- ☐ Dressing self
- ☐ Tying shoe laces
- ☐ Accidentally knocking things over

C. Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- ☐ Destructive behavior
- ☐ Is affectionate with family and friends
- ☐ Responds well to authority figures
- ☐ Boundless energy and poor judgment
- ☐ Withdrawn and/or sullen
- ☐ Cruelty to animals
- ☐ Disorganized, loses things often
- ☐ Shows sudden outburst of physical aggression
- ☐ Frustrated easily
- ☐ Shifts from one activity to another
- ☐ Has difficulty playing quietly
- ☐ Requires a lot of parent attention
- ☐ Fidgets or squirms in seat
- ☐ Appears to daydream or "zone out" often
- ☐ Appears depressed & unhappy much of the time
- ☐ Explosive temperament
- ☐ Frequently complains about aches and pains
- ☐ Appears to have low self-esteem
- ☐ Prefers to be alone (or considers self "a loner")
- ☐ Starts fires
- ☐ Lacks motivation
- ☐ Steals or lies
- ☐ Becomes upset with change
- ☐ Fearfulness
- ☐ Frequent peer and/or family conflicts
- ☐ Does not appear to listen to what is being said
- ☐ Always worrying about something
- ☐ Nervous habits (nail biting, hair twirling, etc.)

D. Home Behavior:

How often each of the following settings a *problem** for your child?
**Problems* include: doesn't follow directions/rule, needs reminders, arguments/fights, whines/cries, fidgets/squirms, etc.

• While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
• When eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
• When playing by him/herself	☐ Rarely	☐ Sometimes	☐ Frequently
• When playing with siblings / children in neighborhood	☐ Rarely	☐ Sometimes	☐ Frequently
• When with a babysitter or at daycare	☐ Rarely	☐ Sometimes	☐ Frequently
• In public places where needs to behave (church, store, etc)	☐ Rarely	☐ Sometimes	☐ Frequently
• When in the car	☐ Rarely	☐ Sometimes	☐ Frequently
• When told to do something he/she doesn't want to do	☐ Rarely	☐ Sometimes	☐ Frequently
• During sit-sown homework time	☐ Rarely	☐ Sometimes	☐ Frequently
• When watching TV or playing a video game	☐ Rarely	☐ Sometimes	☐ Frequently

How would you describe your child's personality at home?

_____

_____

How does your child get along with brothers/sisters? _____

_____

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* that your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.)_____

_____

How does your child respond to discipline? _____

List any responsibilities your child has at home: _____

_____

Does your child do these regularly? □Yes □ No Does your child need frequent reminders? □Yes □ No

Indicate child's... Bed time? ____:____PM Wake time? ____:____ AM Does child sleep well? _____

How much time does your child typically spend on electronic media?
Watching T V: _____hrs/day; Playing video/computer games: _____hrs/day; Other_____: _____hrs/day

Have any family members expressed concerns about your child's behavior? □ Yes □ No
Explain: _____

E. Social Behavior:

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?)

_____

_____

How does your child interact with children in the neighborhood?

_____

_____

IV. Educational History

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____
How much of a struggle is homework? □ Not a struggle □ Sometimes a struggle □ Often a struggle

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? □ Yes □ No
If yes, which program and when services begin_____

_____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool / Daycare_____

_____

_____

Elementary School_____

_____

_____

_____

_____

Middle School_____

_____

_____

_____

High School _____

_____

_____