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Developmental History Questionnaire

Today's Date
Child's Name
Date of Birth
Age
Address
Telephone #
Parent e-mail address
Grade

Insurance company
Subscriber # on your insurance card
Subscriber Name
Subscriber Date of Birth
Subscriber's Employer

Pediatrician's name and practice name

By whom were you referred?

Parent 1 – name, age, occupation
Parent 2 – name, age, occupation

Siblings (names and ages):

Others living in the home:

Are there any close relatives who are not living at home? For example, a noncustodial parent, or a sibling at college or in the military?

What concerns do you have about your child?

When did these problems start?

What information are you hoping that the evaluation will provide?

General Developmental History

Was your child born earlier than the usual nine months gestation? If so, how early?

Were there any medical complications before or after birth?

Your child's birth weight pounds ounces

How would you describe your child as a baby?

As an infant, did your child have difficulty with feeding?

Sleep?

Did your child's early motor and language development seem on target?

Did he or she receive any Early Intervention services? Please be specific.

When did your child begin to

Crawl	
Sit up, without support	
Walk without support	
Speak a few words	
Put words together	
Be toilet trained during the day	
Be toilet trained at night	

Is your child left- or right-handed?

Medical and Health

Has your child had any serious illnesses, operations, or injuries?

Does he or she have a history of ear infections? How many?

Does your child have allergies? Please list them.

Please list any medication (prescription or over the counter) your child uses.

Has your child been seen by any medical specialists? Please describe.

Are there any other medical concerns about your child? Please be specific.

Speech and Language

Are any languages besides English spoken in your home? If so, what is the primary language?

As a baby, did your child smile at you in response to your smile? Imitate sounds or facial expressions?

Did your child respond to his or her name being called, by around age one?

Did your child point, to show you things, by about age one?
If not, when did pointing begin?

When did your child begin to use words to communicate?

When did two-word combinations and short sentences begin to appear?

Does your child have difficulty communicating now? If so, please describe.

Please describe any other concerns you have about your child's speech and language development.

Motor Coordination

What activities does your child enjoy on a playground?

Is there any activity which he or she dislikes? Anything that he or she seems to not be able to do as well as others the same age?

Does your child seem uncoordinated? If so, please describe.

Does he or she have difficulty learning new motor skills?

Does your child enjoy playing with fine-motor toys such as beads, puzzles, and Legos?

Sensory

Does your child have any unusual reactions to sights, sounds, or touch?

Does your child avoid making eye contact?

Is your child picky about food or clothing textures?

Does he or she become over-stimulated in busy or noisy places? If so, please describe.

Social and Play Development

What play activities and toys does your child enjoy?

How would you describe your child's temperament?

How does your child interact with other children?

Besides siblings, does he or she have any preferred friends?

Does his or her attention span, or behavior, affect the ability to play with peers?

How does your child occupy him or herself when left alone?

Does your child have any intense interests or preoccupations? Please describe.

Family History

Where was your child born?

Is he or she a biological, adopted, or foster child?

How does your child relate to other family members?

Has anything traumatic happened in your child's life (such as separation from a parent, death of a relative) that might have upset him or her?

Do any relatives, including extended family, have learning disabilities, attention deficit disorder, or a mental health diagnosis such as anxiety or depression?

Education

Where does your child go to school? (If in preschool, how many hours per week?)

Does your child receive any special educational or Early Intervention services? If so, please list them.

How does your child feel about school?

What is easy for him or her in school, and what is harder?

How do you feel about his or her present educational program?

Additional Information:

Please describe your child's strengths and best qualities.

Please use the space below to discuss any other relevant information about your child or any other concerns which you might have.