Green Leaf Psychological Services, Inc.
Child Developmental History Form

Thank you for choosing Green Leaf Psychological for this assessment of your child.

Although this questionnaire is lengthy, we ask that you take the time to complete it and return it as soon as possible. Your answers on this questionnaire combined with interviews and testing will help us determine the causes of current difficulties and will allow us to provide appropriate recommendations.

As such, the completion of this form is a required component of the assessment - we will not be able to begin writing the final report without it.

All information provided in this questionnaire will be considered strictly confidential.

Thanks again for choosing us…let's get started!

Date: _____(DD/MM/YYYY)

Person completing this form: _____

CHILD

Child's name: _____
Last First Middle

Birthday: _____(DD/MM/YYYY) Age: ____ Gender: _____

Adopted: ____ Yes ____ No If so, at what age? _____ Does child know? ____Yes ____ No

Home address: _____

City: _____ Province: _____ Postal code: _____

PARENT / GUARDIAN 1

Name: _____ Age: _____ Education: _____

Biological parent? YES NO

Address (if different from above): _____

Phone: _____

Email: _____

Occupation (if applicable):_____

PARENT / GUARDIAN 2

Name: _____ Age: _____ Education: _____

Biological parent? YES NO

Address (if different from above): _____

Phone: _____

Email: _____

Occupation (if applicable): _____

OTHER PARENT / GUARDIAN (if applicable)

Name: _____ Age: _____ Education: _____

Biological parent? YES NO

Address (if different from above): _____

Phone: _____

Email: _____

Occupation (if applicable):_____

YOUR MARITAL STATUS

___ Married for _____ years ___ Lived together for _____ years ___ Separated

___ Single ___ Divorced ___ Widowed

OTHER FAMILY MEMBERS LIVING IN HOME

Name/Age: _____ Name/Age: _____

Name/Age: _____ Name/Age: _____

Children not living in the home: _____

REASON FOR CONTACT

My reason for having my child assessed is: _____

_____

Other (related) concerns are _____

Problem has been going on (weeks, months, year or more) _____

RECENT STRESSORS

Have any of the following events occurred within the past 2 years?

Birth of sibling	___ Yes	___ No
Parents divorced or separated	___ Yes	___ No
Family accident or illness	___ Yes	___ No
Death in family	___ Yes	___ No
Parent changed job	___ Yes	___ No
Changed schools	___ Yes	___ No
Family moved	___ Yes	___ No
Family financial problems	___ Yes	___ No

Other _____

PREGNANCY HISTORY – MOTHER

How old was the mother when child was born? _____

Were any of the following substances used during pregnancy?

Cigarettes YES NO Packs per day ____

Alcohol: YES NO Amount _____

Other drugs (marijuana, cocaine, etc.)? YES NO

If yes, please provide details _____

BIRTH

Was (s)he born on schedule? ___ Yes ___ No

If premature, by how many weeks? _____
If late, by how many weeks? _____

Were there any health complications following birth? ___Yes ___ No

If yes, please specify _____

INFANCY

Did baby gain weight well? ___ Yes ___ No

Were there early infancy sleep pattern difficulties? ___ Yes ___ No

If so, please describe _____

Did the child experience any health problems during infancy? ___ Yes ___ No

If so, please describe _____

At what age did (s)he sit up? ___ 3-6 months ___7-12 months ___ over 12 months

At what age did (s)he crawl? ___ 4-6 months ___ 7-12 months ___ over 12 months

At what age did (s)he walk? ___ under 1 year ___ 1-2 years ___ 2-3 years

At what age did (s)he speak single words (other than "mama" or "dada")?
___ 8-13 mos ___ 14-18 mo ___ 19-24 mos ___25-36 mos ___ 37-48 mos

At what age did (s)he speak in simple sentences?
___ 8-13 mos ___ 14-18 mo ___ 19-24 mos ___25-36 mos ___ 37-48 mos

Did your child have early speech problems or was there anything unusual about your child's speech development? ___ Yes ___ No

Please describe _____

MEDICAL HISTORY

Family physician/pediatrician: _____

Address: _____ Phone:_____

When was your child's last check-up? _____(DD/MM/YYYY)

Were any problems noted? ___ Yes ___ No

If yes, what problems? _____

How would you describe his/her health now?
___ very good ___ good ___ fair ___ poor ___ very poor

Has (s)he had any chronic health problems (e.g., asthma, diabetes, heart condition)?

___ Yes ___ No Please specify_____
Age of onset _____

Has your child had any of the following:

Meningitis	___ Yes	___ No
Encephalitis	___ Yes	___ No
Allergies	___ Yes	___ No
Convulsion or seizures	___ Yes	___ No
Other diseases or illnesses	___ Yes	___ No
Ear infections	___ Yes	___ No

Has your child had any accidents resulting in the following?

	Yes	No	Age	Please provide some detail
Broken bones				
Head injury				
Eye injury				
Other				

VISION & HEARING

How is his/her hearing? ___ good ___ fair ___ poor

Has his/her hearing been tested? ___ Yes ___No

If yes, when? _____

How is his/her vision? ___ good ___ fair ___ poor

Prescribed glasses? ___ Yes ___ No

When was his/her vision last tested? _____

Is your child on any medication? ___ Yes ___ No

Please specify _____

EATING HABITS

Does your child have any appetite control problems?
___ over-eats ___ under-eats ___ no appetite problems

Any unusual weight gain or weight loss? ___ Yes ___ No

Is your child on a special diet? ___ Yes ___ No

Please specify _____

Is your child allergic to any foods? ___ Yes ___ No

Please specify _____

SLEEP HABITS

Does your child have any problems sleeping?
___ None ___ Difficulty falling asleep ___ Difficulty staying asleep
___ Early morning awakening ___ Sleep terrors ___ Sleep walking
___ Frequent nightmares

Does (s)he go to sleep at approximately the same time each night on school days?
___ Yes ___ No

If not, please specify _____

Does your child have bladder control problems at night? ___ Yes ___ No
If yes, how often?

GENERAL ACTIVITY

How would you rate your child's overall physical activity when compared with other children similar in age, size, etc.?
___ less active ___ about the same ___ more active

When sitting, does your child move his/her hands, fingers, feet and/or legs excessively?
___ rarely ___ sometimes ___ often

Does your child do things impulsively which result in spills, tripping, breakage, bruises, etc.?
___ rarely ___ sometimes ___ often

Do you think that your child talks too much?
___ rarely ___ sometimes ___ often

Does your child "take turns" and otherwise play well with other children?
___ rarely ___ sometimes ___ often

How well does your child stay with a specific activity, such as reading, playing a sit-down game, or some small task?
___ very well ___ fairly well ___ poorly

Based on your observations of your child dressing himself/herself, rate the following:

	No problem	Can do, but takes time	Can't do alone
Buttoning clothes			
Putting on shirts and pants			
Tying shoe laces			

Compared to children of similar age and physical size, does your child:

	Yes	No	Don't know
Throw a ball accurately?			
Catch a ball well?			
Ride a bicycle?			

LANGUAGE

Does your child have any speech difficulties?

YES NO

If yes, please describe _____

Has (s)he had speech and language therapy? YES NO

If so, please specify _____

How is his/her speech articulation now? ___ good ___ fair ___ poor

Do you feel your child sometimes does not understand what is being said to him or her?
___ rarely ___ sometimes ___ often ___ not applicable

Does your child seem to have unusual trouble listening when spoken to?
___ rarely ___ sometimes ___ often ___ not applicable

Do you feel your child sometimes does not hear well?
___ rarely ___ sometimes ___ often ___ not applicable

Do you feel he/she cannot remember your instructions when asked to do something?
___ rarely ___ sometimes ___ often ___ not applicable

MEMORY

Do you feel he/she has memory problems of any kind?
___ rarely ___ sometimes ___ often ___ not applicable

If so, what kind of memory problems concern you?
___ Short term (approximately 30 seconds, e.g., remembering a phone number)
___ Long term (memory for events days, weeks, or months in the past)
___ Memory of visual information
___ Memory of auditory information
___ Word finding (having difficulty finding words when trying to say something)

ATTENTION

Which of the following are considered to be significant problems at the present time?

	Yes	No	At what age did this begin?
Fidgets			
Difficulty remaining seated			
Easily distracted			
Difficulty awaiting turn			
Often blurts out answers to questions before they have been completed			
Difficulty following instructions			
	Yes	No	At what age did this begin?
Difficulty sustaining attention			
Shifts from one activity to another			
Difficulty playing quietly			
Often talks excessively			
Often interrupts or intrudes on others			
Often does not listen			
Often loses things			
Often engages in physically dangerous activities			

OTHER

Has your child shown any of the following?

Fainting spells	___ Yes	___ No
Daredevil behaviour	___ Yes	___ No
Rocking	___ Yes	___ No
Hand flapping	___ Yes	___ No
Head bumping	___ Yes	___ No
Nail biting	___ Yes	___ No

Do you have any suspicion that your child is abusing alcohol or drugs?

___ Yes ___ No ___ Unsure

EMOTIONAL EXPERIENCE

Compared with other children his/her age, does your child:

	Slower	Faster	The same
Become angry…			
Cry…			
Laugh…			

Do his/her emotions appear stronger than those of the other children his/her age?
___ rarely ___ sometimes ___ often

Does your child get extremely upset at disappointments?
___ rarely ___ sometimes ___ often

Is your child especially excitable?
___ rarely ___ sometimes ___ often

Would you describe your child as especially anxious or fearful? ___ Yes ___ No

If yes, please describe what you mean:

Which of the following are considered to be a significant problem at the present time?

	Yes	No	At what age did this begin?
Unrealistic and persistent worry about possible harm to attachment figures			
Unrealistic and persistent worry that an event will separate the child from parents			
Persistent school refusal			
Persistent refusal to sleep alone			
Persistent avoidance of being alone			
Repeated nightmares re: separation			
Physical complaints			
Excessive distress in anticipation of separation from parents			
Excessive distress when separated from home or parents			
Unrealistic concern about competence			
Marked self-consciousness			
Excessive need for reassurance			
Marked inability to relax			

Would you describe your child as depressed? ___ Yes ___ No

If yes, please describe _____

_____

_____

_____

Which of the following are considered to be a significant problem at the present time?

Depressed or irritable mood most of the day, nearly every day
___ Yes ___ No

Diminished pleasure in activities ___ Yes ___ No

Decrease or increase in appetite
___ Yes ___ No

Insomnia or hypersomnia nearly every day ___ Yes ___ No

Psychomotor agitation or retardation ___ Yes ___ No

Fatigue or loss of energy ___ Yes ___ No

Feelings of worthlessness or excessive inappropriate guilt ___ Yes ___ No

Diminished ability to concentrate ___ Yes ___ No

Suicidal ideation or attempt ___ Yes ___ No

SOCIAL HISTORY

Child ___ gets along with ___ does not get along with family

With whom does he/she get along best? _____

With whom are there most difficulties? _____

How does the child get along with his/her brothers/sisters?
___ worse than average ___ average ___ better than average

How easily does the child make friends?
___ worse than average ___ average ___ better than average

School personnel have reported that your child:
___ gets along with other children ___ doesn't get along with other children

Has your child exhibited any of the following symptoms:

Little or no interest in peers	___ Yes	___ No
Age-inappropriate indiscreet remarks	___ Yes	___ No
Initiates or terminates interactions inappropriately	___Yes	___ No
Abnormal social behavior	___ Yes	___ No
Excessive reaction to changes in routine	___ Yes	___ No
Abnormalities of speech	___ Yes	___ No

CURRENT BEHAVIOUR

On average, what percentage of the time does your child comply with initial commands?
___ 0-20% ___ 20-40% ___ 40-60% ___ 60-80% ___ 80-100%

On average, what percentage of the time does your child eventually comply with commands?
___ 0-20% ___ 20-40% ___ 40-60% ___ 60-80% ___ 80-100%

Disciplining child usually creates problems between parents. ___ Yes ___ No
If yes, please describe _____

_____

My discipline is ___ strict ___ not strict ___ half and half

Other parent's discipline is ___ strict ___ not strict ___ half and half

Discipline is usually done by ___ mother ___ father ___ both ___ other

To what extent are you and your partner (if applicable) consistent with respect to disciplinary strategies?
___ most of the time ___ some of the time ___ none of the time

What strategies have been implemented to address problems?

	Yes	No	Successful?
Verbal reprimands			
Time out (isolation)			
Removal of privileges			
Rewards			
Physical punishment			
Giving in			

Which of the following are considered to be a significant problem at the present time?

	Yes	No	At what age s(he) begin?
Often loses temper			
Often argues with adults			
Often actively defies or refuses adult requests or rules			
Often deliberately does things that annoy other people			
Often blames others for own mistakes			
Often touchy or easily annoyed by others			
Is often angry or resentful			
Often swears or uses obscene language			
Run away from home overnight at least twice			
Lies often			
Deliberate fire-setting			
Often truant			
Breaking and entering			
Destroyed others' property			
Cruel to animals			
Forced someone else into sexual activity			
Used a weapon in a fight			
Often initiates physical fights			
Stolen with confrontation			
Stolen without confrontation			
Physically cruel to people			

TREATMENT HISTORY

Has the child ever had any of the following?

	Yes	No	Duration and when
Individual psychotherapy			
Group therapy			
Family therapy with child			
In-patient evaluation			
Residential treatment			
Incarceration for legal offense			

SCHOOL HISTORY

School: _____ Grade: _____

School phone: _____

Name of classroom teacher: _____

Other teacher or support person who knows your child well: _____

Do you authorize our contacting the school to discuss your child's situation?
___ Yes ___ No ___ would like to discuss further before authorizing

According to the school, child's academic functioning is:
___ average ___ below average ___ above average ___ don't know

Child ___ likes school ___does not like school ___ is indifferent

Has there been significant behavior problems noted? ___ Yes ___No

Please (briefly) summarize school functioning (e.g., academic, social, testing) within each of these grade levels:

Preschool Name of school: _____

Kindergarten Name of school: _____

Grades 1-3 Name of school: _____

Grades 4-6 Name of school: _____

Grades 7-12 Name of school: _____

Has the child been in any type of special educational or behavioural program, and if so, how long?

___ Yes ___ No

_____

Has the child ever been:

	Yes	No	Number of times
Suspended from school			
Retained in grade			

Have school staff noted problems with your child's:

___ sounding words
___ reading comprehension
___ enjoyment of reading
___ reading aloud
___ memory of material read

Is your child's written work, have specific problems been noted with:

___ spelling
___ neatness of handwriting
___ grammar
___ creativity (making up stories, etc,)

Is your child's math work, are there significant problems with:

___ understanding new concepts
___ "mental math"
___ careless errors
___ remembering "math facts"
___ timed test

Do school personnel report the following about your child?

	Yes	No	Don't know
Poor reader			
Distractible			
Inattentive			
Disturbs other children			
Doesn't complete his/her work			
Excessive talking			
Daydreams			
Slow-moving, slow responding			
Fights			
Gets out of seat without permission			
Difficulty following instructions			
Difficulty thinking of words to say			
Other: _____			

FAMILY HISTORY

___ Parent / Guardian 1 ___ Parent / Guardian 1 ___ neither ___ Both had/have trouble similar to those your child is experiencing now.

Other children in the home have problems with ___school behavior ___ grades

___ learning disorder/disability, and if so, what? _____

___ illness ___ family ___ friends ___ other ___ none of the above

Maternal Relatives (Birth mother's or adoptive mother's family).

Please check if there is a positive history with the following:
Please note:

"Self" denotes child's birth or adoptive mother (if child's mother is completing this form)
"Mother" would denote *your* mother (child's grandmother)
"Siblings" would denote *your siblings* (if child's mother is completing this form)

				Siblings				
	Self	Mother	Father	Bro	Bro	Sis	Sis	Total
Problems with aggressiveness, defiance, & oppositional behavior as a child								
Problems with attention, activity, and impulse control as a child (including ADHD)								
Developmental delay/autism								
Learning disability								
Speech problems								
Failed to graduate from high school								
Reading problems (e.g., trouble learning to read; slow, halting reading aloud; etc.								
Psychosis or schizophrenia								
Depression for greater than two weeks								
Anxiety disorder that impaired adjustment								
Tics and Tourette's syndrome								
Alcohol abuse								
Substance abuse								
Antisocial behavior (assaults, threats, etc.)								
Arrests								

Paternal Relatives (Birth mother's or adoptive father's family).

Please check if there is a positive history with the following:
"Self" denotes child's birth or adoptive father (if child's father is completing this form)
"Father" would denote *your* father (child's grandfather)
"Siblings" would denote *your siblings* (if child's father is completing this form)

				Siblings				
	Self	Mother	Father	Bro	Bro	Sis	Sis	Total
Problems with aggressiveness, defiance, & oppositional behavior as a child								
Problems with attention, activity, and impulse control as a child (including ADHD)								
Developmental delay/autism								
Learning disability								
Speech problems								
Failed to graduate from high school								
Reading problems (e.g., trouble learning to read; slow, halting reading aloud; etc.								
Psychosis or schizophrenia								
Depression for greater than two weeks								
Anxiety disorder that impaired adjustment								
Tics and Tourette's syndrome								
Alcohol abuse								
Substance abuse								
Antisocial behavior (assaults, threats, etc.)								
Arrests								

Child's Siblings

	Siblings				
	Bro	Bro	Sis	Sis	Total
Problems with aggressiveness, defiance, & oppositional behavior as a child					
Problems with attention, activity, and impulse control as a child (including ADHD)					
Developmental delay/autism					
Learning disability					
Speech problems					
Failed to graduate from high school					
Reading problems (e.g., trouble learning to read; slow, halting reading aloud; etc.					
Psychosis or schizophrenia					
Depression for greater than two weeks					
Anxiety disorder that impaired adjustment					
Tics and Tourette's syndrome					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, threats, etc.)					
Arrests					

Signature of person completing this form _____

Thank you for your assistance!

(and we apologize for the length of the questionnaire :)