



Kristin Rose, PsyD.
202 W, Sandy Lake Rd.
Suite 105
Coppell, TX 75019
972-999-6490
DrRose@RoseTherapyCenter.com

Developmental Background Questionnaire:

This is a detailed questionnaire that will help me greatly in learning about and understanding your child. Please answers the question the best you can and I will answer any questions you have. If possible, it would be helpful for both parents to fill out the questionnaire together.

Demographic Information:

Child's name: Date of Birth:
Name(s) of person(s) completing this form:
Date:

Information about Parents:

Mother's Name: Father's Name:
DOB: DOB:
Highest level of education: Highest level of education:
Occupation: Occupation:

For Parents who are divorced and remarried:

Step-parent's Name: Step-parent's Name:
DOB: DOB:
Highest level of education: Highest level of education:
Occupation: Occupation:

What arrangements, if any, are there for visitation or shared custody?

List all people living in the household:

Table with 3 columns: Name, Relationship to Child, Age. Includes three blank rows for data entry.

List all brothers, sisters or other significant people living outside the household:

Table with 3 columns: Name, Relationship to Child, Age. Includes three blank rows for data entry.

Recent family stressors (deaths, births, moves, job loss, etc.):

Dominant language spoken in the home: \_\_\_\_\_

Other languages spoken in the home: \_\_\_\_\_

Name of pediatrician: \_\_\_\_\_

Name of other significant health care providers: \_\_\_\_\_

Who referred you to Rose Assessment & Therapy Center? \_\_\_\_\_

**Presenting Problem:**

Briefly describe your child's current difficulties:

How long has this problem been of concern to you?

When was this problem first noticed?

Has your child received evaluation or treatment for the current problem or similar problems? If yes, please list any therapists, counselors or agencies who have worked with your child.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child being treated for a medical illness?  Yes  No

If yes, for what condition is the child being treated?

Is your child on any medications at this time?  Yes  No

If yes, please fill out the chart below:

| Medication | Dosage | Reason for medicine |
|------------|--------|---------------------|
|            |        |                     |
|            |        |                     |
|            |        |                     |
|            |        |                     |
|            |        |                     |

**Pregnancy and Birth History:**

Is your child:  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:

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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: \_\_\_\_\_

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Were there any problems during the pregnancy with your child?  Yes  No

If yes, please describe

Was your child exposed to cigarette smoke in utero?  Yes  No

Details:

Was your child exposed to any other problematic substances in utero (e.g. drugs, alcohol, X-rays, chemicals, etc)?  Yes  No

Details:

Was your child exposed to any infectious diseases in utero?  Yes  No

Details:

How long was labor?

Was a c-section performed?

Were there any complications associated with the delivery? (e.g. Umbilical cord around neck, lack of oxygen, meconium staining, jaundice, etc.)

Was Neonatal care needed?  Yes  No

If yes, what kind of care and how long was it needed?

- NICU
- Special Care Nursery
- Other

Was there anything else unusual about pregnancy or birth?

**Infancy:**

Were there any birth defects or complications?  Yes  No

If yes, please describe:

Were there any feeding problems?  Yes  No

If yes, please describe:

Were there any sleeping problems?  Yes  No

If yes, please describe:

Describe your child as an infant (quiet, alert, fussy, etc.)

Did your child like to be held as an infant?  Yes  No

Did your child grow normally?  Yes  No

### **First Years / Developmental History:**

Did your child exhibit any of the following behaviors during the child's first years? Place a check next to each one that he or she showed:

- |   |  |
|---|--|
| <input type="checkbox"/> Did not enjoy cuddling               | <input type="checkbox"/> Had gross-motor problems                    |
| <input type="checkbox"/> Was not calmed by being held         | <input type="checkbox"/> Did not babble                              |
| <input type="checkbox"/> Was colicky                          | <input type="checkbox"/> Did not speak                               |
| <input type="checkbox"/> Was excessively restless             | <input type="checkbox"/> Had excessive fears                         |
| <input type="checkbox"/> Had poor sleep patterns              | <input type="checkbox"/> Ignored toys                                |
| <input type="checkbox"/> Banged head frequently (describe)    | <input type="checkbox"/> Was attached to an unusual object (specify) |
| <input type="checkbox"/> Was constantly into everything       | <input type="checkbox"/> Was unaware of painful bumps or falls       |
| <input type="checkbox"/> Had an excessive number of accidents | <input type="checkbox"/> Had peculiar pattern of speech              |
| <input type="checkbox"/> Was exposed to lead                  | <input type="checkbox"/> Preferred to play alone                     |
| <input type="checkbox"/> Had fine-motor problems              | <input type="checkbox"/> Had poor eye contact                        |
| <input type="checkbox"/> Was not interested in other children | <input type="checkbox"/> Was insensitive to cold or pain             |
| <input type="checkbox"/> Did not smile socially               | <input type="checkbox"/> Did not wave bye-bye                        |

### **Motor Development:**

Age crawled alone \_\_\_\_\_ Walked alone \_\_\_\_\_

Was your child slow to develop motor skills or awkward compared to siblings, friends (e.g. Running, skipping, climbing, biking, playing ball?)

\_\_\_\_\_

Handedness: Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_

Family history of left handedness? (List relatives) \_\_\_\_\_

Was Physical Therapy ever necessary? (when?) \_\_\_\_\_

Was Occupational Therapy ever necessary? (when?) \_\_\_\_\_

### **Speech/Language Development:**

Age spoke first word \_\_\_\_\_ put 2-3 words together \_\_\_\_\_

Speech delays/problems (e.g. Stutters, difficult to understand)? \_\_\_\_\_  
 Oral-motor problems (e.g. Late drooling, poor sucking, poor chewing)? \_\_\_\_\_  
 Was speech/language therapy ever necessary? \_\_\_\_\_

Was child slow to learn the alphabet? \_\_\_\_\_ name colors? \_\_\_\_\_ count? \_\_\_\_\_

Were there any other special problems in the growth and development of your child during the first few years?  Yes  No  
 If yes, Please describe:

**Language and Speech Checklist:**

- |  |   |
|--|---|
| <input type="checkbox"/> Speaks in shorter sentences than expected for age         | <input type="checkbox"/> Is often hoarse                                      |
| <input type="checkbox"/> Does not know names of common objects                     | <input type="checkbox"/> Has unusually loud speech                            |
| <input type="checkbox"/> Has difficulty recalling familiar words                   | <input type="checkbox"/> Has unusually soft speech                            |
| <input type="checkbox"/> Substitutes vague words (e.g. "thing") for specific words | <input type="checkbox"/> Makes sound but no words                             |
| <input type="checkbox"/> Responds better to gestures than to words                 | <input type="checkbox"/> Mixes up the order of events                         |
| <input type="checkbox"/> Does not make appropriate gestures to communicate         | <input type="checkbox"/> Seems uninterested in communicating                  |
| <input type="checkbox"/> Uses gestures instead of words to express ideas           | <input type="checkbox"/> Prefers to speak to adults only                      |
| <input type="checkbox"/> Has difficulty making speech understood                   | <input type="checkbox"/> Prefers to speak to children only                    |
| <input type="checkbox"/> Speaks very slowly  | <input type="checkbox"/> Prefers to speak to family members only              |
| <input type="checkbox"/> Speaks too fast   | <input type="checkbox"/> Speaks in monotone, sing song, or exaggerated manner |

**Medical History:**

Place a check next to any illness or conditions that your child has had. When you check an item, also note the approximate age of the child when he or she had the illness or condition:

|   | Age   |  | Age   |
|---|-------|--|-------|
| <input type="checkbox"/> Measles                        | _____ | <input type="checkbox"/> Frequent headaches        | _____ |
| <input type="checkbox"/> Head Injuries                  | _____ | <input type="checkbox"/> Difficulty concentrating  | _____ |
| <input type="checkbox"/> Mumps                          | _____ | <input type="checkbox"/> Memory problems           | _____ |
| <input type="checkbox"/> Chicken pox                    | _____ | <input type="checkbox"/> Extreme tiredness         | _____ |
| <input type="checkbox"/> Whooping cough                 | _____ | <input type="checkbox"/> Rheumatic fever           | _____ |
| <input type="checkbox"/> Diphtheria                     | _____ | <input type="checkbox"/> Epilepsy                  | _____ |
| <input type="checkbox"/> Polio                          | _____ | <input type="checkbox"/> Tuberculosis              | _____ |
| <input type="checkbox"/> Scarlet fever                  | _____ | <input type="checkbox"/> Bone or joint disease     | _____ |
| <input type="checkbox"/> Meningitis                     | _____ | <input type="checkbox"/> Gonorrhea or syphilis     | _____ |
| <input type="checkbox"/> Encephalitis                   | _____ | <input type="checkbox"/> Anemia                    | _____ |
| <input type="checkbox"/> High fever                     | _____ | <input type="checkbox"/> Jaundice                  | _____ |
| <input type="checkbox"/> Convulsions                    | _____ | <input type="checkbox"/> Hepatitis                 | _____ |
| <input type="checkbox"/> Allergies (please list): _____ | _____ | <input type="checkbox"/> Cancer (list type): _____ | _____ |
| <input type="checkbox"/> Injuries to head               | _____ | <input type="checkbox"/> Diabetes                  | _____ |
| <input type="checkbox"/> Seizures                       | _____ | <input type="checkbox"/> High blood pressure       | _____ |
| <input type="checkbox"/> Broken bones                   | _____ | <input type="checkbox"/> Heart disease             | _____ |
| <input type="checkbox"/> Hearing problems               | _____ | <input type="checkbox"/> Asthma                    | _____ |
| <input type="checkbox"/> Ear infections (tubes needed?) | _____ | <input type="checkbox"/> Bleeding problems         | _____ |
| <input type="checkbox"/> Sleeping problems              | _____ | <input type="checkbox"/> Eczema or hives           | _____ |
| <input type="checkbox"/> Fainting spells                | _____ | <input type="checkbox"/> Suicide attempts          | _____ |
| <input type="checkbox"/> Loss of consciousness          | _____ | <input type="checkbox"/> Sleeping problems         | _____ |
| <input type="checkbox"/> Paralysis                      | _____ | <input type="checkbox"/> HIV                       | _____ |
| <input type="checkbox"/> Dizziness                      | _____ | <input type="checkbox"/> AIDS                      | _____ |

Does your child have any disabilities?

Has your child had any serious illnesses?

Has your child been hospitalized?

Has your child had any operations?

Has your child had any accidents?

Are your child's immunizations up to date?

Child's height? \_\_\_\_\_ Child's weight? \_\_\_\_\_

Do you have concerns regarding your child's weight or eating habits? \_\_\_\_\_

\_\_\_\_\_

Date of any vision evaluation: \_\_\_\_\_ Results: \_\_\_\_\_

Date of any hearing evaluation: \_\_\_\_\_ Results: \_\_\_\_\_

### **Family Medical History:**

Place a check next to any illness or conditions that any member of the immediate family has had. When you check an item, please note the family member's relationship to the child.

#### Relationship to Child

- |  |       |
|--|-------|
| <input type="checkbox"/> Academic problem or Learning Disability     | _____ |
| <input type="checkbox"/> Alcoholism                                  | _____ |
| <input type="checkbox"/> Cancer                                      | _____ |
| <input type="checkbox"/> Depression                                  | _____ |
| <input type="checkbox"/> Developmental problem or Mental Retardation | _____ |
| <input type="checkbox"/> Diabetes                                    | _____ |
| <input type="checkbox"/> Drug problem                                | _____ |
| <input type="checkbox"/> Emotional problem                           | _____ |
| <input type="checkbox"/> Epilepsy                                    | _____ |
| <input type="checkbox"/> Autism/ Asperger's                          | _____ |
| <input type="checkbox"/> Anxiety                                     | _____ |
| <input type="checkbox"/> Heart trouble                               | _____ |
| <input type="checkbox"/> Neurological disease                        | _____ |
| <input type="checkbox"/> Suicide attempt                             | _____ |
| <input type="checkbox"/> Other problem (please list)                 | _____ |

**Educational Checklist:**

- Has difficulty with reading
- Has difficulty with arithmetic
- Has difficulty with spelling
- Has difficulty with handwriting
- Has difficulty with other subjects (please list)

\_\_\_\_\_

\_\_\_\_\_

- Has difficulty paying attention in class
- Has difficulty sitting still in class
- Has difficulty waiting turn in school

- Has difficulty taking notes in class
- Has difficulty respecting others' rights
- Has difficulty remembering things
- Forgets homework
- Has difficulty getting along with teacher
- Has difficulty getting along with other children
- Dislikes school
- Resists going to school
- Refuses to do homework

**Educational History** (Please write in name of school and approximate dates of attendance)

|               |              |
|---------------|--------------|
| Preschool     | Dates: _____ |
| Kindergarten  | Dates: _____ |
| Elementary    | Dates: _____ |
|               | Dates: _____ |
| Middle School | Dates: _____ |
|               | Dates: _____ |
| High School   | Dates: _____ |
|               | Dates: _____ |

What is his or her current grade? \_\_\_\_\_

How are your child's grades or marks? \_\_\_\_\_

Is your child in any special education classes?  Yes  No

If yes, what type of class? \_\_\_\_\_

Has your child been held back in a grade?  Yes  No

If yes, what grade and why? \_\_\_\_\_

Has your child ever received special tutoring or therapy in school?  Yes  No

If yes, please describe: \_\_\_\_\_

Has your child ever received special tutoring or therapy outside of school?  Yes  No

If yes, please describe: \_\_\_\_\_

Has your child's school performance recently declined?  Yes  No

If yes, please describe: \_\_\_\_\_

Has your child missed a lot of school?  Yes  No

If yes, please indicate reasons: \_\_\_\_\_

Does your child attend day care after school? \_\_\_ Where? \_\_\_\_\_ How many hours a day?

## Social and Behavioral Checklist:

Place a check next to any behavior or problem that your child *currently* exhibits:

- Has difficulty with hearing
- Has difficulty with vision
- Has difficulty with coordination
- Has difficulty with balance
- Has difficulty making friends
- Has difficulty keeping friends
- Refuses to share
- Prefers to be alone
- Does not get along well with brothers/sisters
- Fights verbally with adults
- Yells and calls children names
- Shows wide mood swings
- Is aggressive (describe) \_\_\_\_\_
- Is withdrawn (describe) \_\_\_\_\_
- Is shy or timid
- Clings to others
- Tires easily, has little energy
- Is more interested in things (objects) than people
- Engages in behavior that could be dangerous to self or others (describe) \_\_\_\_\_
- Breaks objects deliberately
- Lies (describe) \_\_\_\_\_
- Steals (describe) \_\_\_\_\_
- Injures self often accidentally
- Injures self on purpose
- Runs away
- Has low self-esteem
- Blames others for his or her troubles
- Is argumentative
- Does not get along well with other children
- Fights verbally with other children
- Fights physically with other children
- Does not show feelings
- Has frequent crying spells
- Has unusual or special fears, habits, or mannerisms (describe) \_\_\_\_\_
- Wets bed
- Sleepwalks
- Sucks thumb
- Bites nails
- Has frequent temper tantrums
- Has trouble sleeping (describe) \_\_\_\_\_
- Rocks back and forth
- Bangs head
- Snores while sleeping
- Eats poorly
- Is stubborn
- Has poor bowel control (soils self)
- Is much too active
- Is fidgety
- Is easily distracted
- Is disorganized
- Is clumsy
- Takes unnecessary risks
- Gets hurt frequently
- Has too many accidents
- Doesn't learn from experience
- Feels that he or she is bad
- Is slow to learn
- Moves slowly
- Stares into space for long periods
- Engages in repetitive behavior (e.g. Hand flapping, wheel spinning) \_\_\_\_\_
- Does not understand other people's feelings
- Has difficulty following directions
- Gives up easily
- Complains of aches or pains
- Is disobedient
- Has tics or twitches
- Constantly seeks attention
- Has periods of confusion or disorientation
- Is restless
- Is jealous (describe) \_\_\_\_\_
- Is extremely selfish
- Feels hopeless
- Is nervous or anxious
- Is immature
- Is easily frustrated
- Has difficulty learning when there are distractors
- Is suspicious of other people
- Requires constant supervision
- Has difficulty resisting peer pressure
- Shows anger easily
- Has difficulty accepting criticism
- Feels sad or unhappy often
- Talks about wanting to die
- Has poor attention span
- Has poor memory
- Sets fires
- Is afraid of new situations
- Has trouble making plans
- Eats inedible objects
- Is not toilet trained
- Uses illegal drugs (describe) \_\_\_\_\_
- Drinks alcohol
- Shows sexually provocative behavior
- Has extreme fear of bathroom or bathing
- Has anxiety when separated from parents
- Has extreme anxiety about going to school
- Has fear of bedtime
- Is wary of any physical contacts with adults in general
- Refuses to sleep alone
- Refuses to go to bed
- Has loss of bladder control
- Is fearful of strangers



- Is unusually talkative
- Is forgetful
- Has blank spells
- Daydreams too much
- Worries a lot
- Is impulsive

- (in cases of divorce) Is fearful of visiting a parent or caregiver
- Overeats
- Is very eager to please others
- Has compulsion about cleanliness – wanting to wash or feeling dirty all the time
- Other Problems (describe) \_\_\_\_\_

**Child’s Activities:**

What does your child like to do for fun?

List any after school activities that your child participates in:

- 1.
- 2.
- 3.
- 4.
- 5.

Does your child have any special areas of talent?

What is your child’s favorite thing to do with free time?

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? \_\_ Yes \_\_ No

How much time does your child typically spend on electronic media?

\_\_\_\_\_

Watching TV: \_\_\_\_\_ hrs/day; Playing video/computer games: \_\_\_\_\_ hrs/day; Other: \_\_\_\_\_ hrs/day

What do you hope to learn from the present evaluation?

Please indicate any daily routines that you and your child have (i.e. evening routine):

Has your child ever been in trouble with the law?

What activities do you and your child enjoy together?

Does your child ask religious/spiritual questions? How have you handled these questions?

List three of your child's strengths

List your child's greatest weakness

Thank you for taking the time to fill out this questionnaire.