CHILD & ADOLESCENT/TEEN
DEVELOPMENTAL NEUROBEHAVIORAL DATABASE

Child's Name:___________________________________ Today's Date: ________________
Birthdate: ___________________
Age: _______________________

School: ____ Grade: _________________

Name of individual filling out questionnaire: _____________________________________

	Biological	Step	Adoptive
Father:			
Mother:			

If parents are divorced, please explain the custody arrangements:

The following questions deal with your reasons for seeking assistance, pregnancy, your child's developmental and medical history, performance in school, and your family history. Please fill this questionnaire in as much detail as possible. Feel free to make notes and provide as much additional information as is needed. If you have any school reports or previous assessments, bring these along. All of this information will be reviewed with you in detail, but it is helpful to have a complete and accurate record to start with. Thank you!

CONTACT FORM

Name:

Relationship:

Mailing Address:

Telephone: Home:______________ Cell: ______________ Work: ______________

Fax:________________ Email:__________________________________

Preferred method of contact (circle one): Home Phone – Cell Phone – Work Phone – Email

Secondary contact (circle one): Home Phone – Cell Phone – Work Phone – Email

Name:

Relationship:

Mailing Address:

Telephone: Home:______________ Cell: ______________ Work: ______________

Fax:________________ Email:__________________________________

Primary contact (circle one): Home Phone – Cell Phone – Work Phone – Email

Secondary contact (circle one): Home Phone – Cell Phone – Work Phone – Email

In case of emergency, please contact (circle one): Father Mother Other:___________________

CURRENT NEEDS

What are your expectations from this evaluation; what do you want to discover?

Are you concerned that your child might be using alcohol or drugs?

If yes, please explain your concerns:

Are you concerned that your child might have been abused or traumatized?

If, yes, please explain your concerns:

Please list your child's current difficulties. Include when you first became concerned and what you think is the cause of the problem.

a)

b)

c)

d)

e)

f)

OBSTETRICAL HISTORY

How old was the mother when pregnant with this child?

How many times was the mother pregnant prior to this pregnancy?

Were there ever any miscarriages or abortions?

If yes, please indicate year and month of pregnancy:

Did the mother see a doctor for prenatal care?

If yes, please indicate which month of pregnancy care was begun:

During the pregnancy, how much weight did the mother gain?

If weight loss occurred, how much was lost?

Please list the name of the hospital in which the baby was born: ______________________________

During this pregnancy, did any of the following occur:

	Yes	**No**	**Please explain**
Amniocentesis			
Bleeding or Spotting			
Placental Abruption			
Kidney Trouble			
High Blood Pressure			
Swelling of Ankles			
Toxemia or Preeclampsia			
Low Salt Diet			
Water Pill (Diuretics)			
Sugar in Urine			
Rh Factor			
Mother receive Rhogam			
Sickle Cell			
Premature Labor			
Maternal Illness (Rashes, Fevers, Infections)			
X-Rays			
Accident			
Hospital Stay			
Cigarettes			
Alcohol			
Maternal Drug Use			
Emotional/Other Stress			

Were any of the following medications taken during the pregnancy?

	Yes	No
Birth Control Pills		
Prenatal Vitamins		
Prenatal Calcium/Iron		
Medicine to Keep Baby (prevent labor)		
Antibiotics		
Anticonvulsants (for seizures)		
Steroids (prednisone)		
Sleep Pills		
Antidepressants		
Tranquilizers		
Reducing Pills		

Were any other medications taken during pregnancy?

If yes, please list them:

Was this a full term (9 month , 38 to 42 week) Pregnancy?

If no, please indicate what week of pregnancy the baby was born:

Did the mother go into labor by herself?

If no, was the labor induced?

Was delivery by Caesarian Section?

If yes, what was the reason for the C-section?

How many hours was the mother in labor?

Was the baby born head first?

If not, what occurred?

Were forceps used?

Was vacuum extraction used?

Apgar Scores: __________ __________

Were there any other complications of delivery?

	Yes	No
Premature rupture of membranes (water broke too early)		
Doctor had to "turn" the baby		
Twins or Triplets		
Hemorrhage		
High Blood Pressure		
Mother had Postpartum Depression		

Were there any other complications?

If yes, please describe them:

Did the baby have any of these problems after delivery?

	Yes	No
Put in an Incubator		
Blueness or Trouble Breathing		
Jaundice (Yellow Skin)		
Convulsions		
Did not feed well		

Were there any other difficulties after delivery?

If yes, please describe them:

What was the birth weight of the child?

When did mother and baby leave the hospital?

DEVELOPMENTAL HISTORY

Did your newborn have any of the following difficulties?

	Yes	No
Colic, excessive irritability, inconsolable crying		
Did not sleep very much		
Too stiff, arched back		
Too floppy		
Sleepy, lethargic – had to wake baby to feed		
Feeding problem		
Breathing problem		
Did not like to be held		
Failure to Thrive		

Did any other difficulties occur that were not listed above?

If yes, please describe them:

When did your child able to sit alone, WITHOUT propping or help?

When did your child start to walk WITHOUT holding on to something?

When did your child start to babble (bababa….gagaga)?

When did your child first speak words with meaning?

When did your child say short sentences, such as "I want milk" or "go bye bye"?

By age 2, was your child's speech clear to other people?

If not, please explain:

Did your child have trouble learning to speak?

If yes, please explain:

Was he/she different from his/her siblings or other children?

If yes, please explain:

Was your child able to follow simple instructions?

If not, please explain:

Did your child have any difficulty chewing or swallowing food?

If yes, please explain:

Is your child toilet trained?

If yes, at what age was toilet training accomplished?

Has your child had difficulty with soiling or wetting after being toilet trained?

If yes, please explain:

When did your child learn to ride a tricycle?

When did your child learn to ride a bicycle without training wheels?

When was your child able to get dressed alone?

When did your child learn to tie shoelaces?

What hand does your child prefer to use?

At what age did you notice this preference:

Before 1 year old *After 2 years old* *After 4 years old*

MEDICAL HISTORY

Has your child ever had any serious medical illness?

If yes, please describe:

Has your child ever had any hospitalizations or operations?

If yes, please complete the following table:

Date	Hospital Name, City and State	Reason for Hospitalization

Has your child ever had any of the following health problems?

	Yes	No	Please describe
Poor vision/Eye problems			
Repeated ear infections			
Hearing loss			
Sinus infections			
Throat infections			
Heart (murmur, irregular heart beat, high blood pressure)			
Pulmonary problems (bronchiolitis, pneumonia, asthma)			
Chronic constipation or diarrhea			
Stomach aches/upset, nausea, vomiting, indigestion			
Kidney, bladder or urinary issues			
Muscle, bone, joint issues			
Fractures			
Skin or hair issues			
Headaches or Migraine headaches			
Seizures			
Head injury, concussion			
Loss of consciousness			
Endocrine (thyroid, etc.)			
Anemia, low white count			
Allergies			
Weight issue			
Poisoning			
Accidents			
Serious injury			
Back pain			
Genetic conditions diagnosed by genetic testing			
Tobacco use			

Has your child ever had any other health problems not listed above?

If yes, please describe:

Does your child have a good appetite?

If no, please explain:

Does your child require any sort of special diet?

If yes, please describe it below:

Does your child get enough exercise?

Please describe the kind and amount:

How many of hours of sleep a night does your child get?

Are school nights the same as weekends and holidays?

If not, please list how much sleep is had on these nights:

Please describe your child's nighttime habits:

	Yes	**No**
Does not like to go to bed		
Can't fall asleep		
Wakes up in the middle of the night		
Wanders around in the middle of the night		
Afraid of the dark		
Nightmares		
Wakes up too early in the morning		
Very hard to wake up		
Snores		
Has pauses or interruptions in breathing while sleeping		
Bedwetting		
Falls asleep or gets drowsy in school		
Sleepwalking		
Repetitive dreams		

If your child has any difficulty sleeping, please take the next seven days to complete the included sleep diary.

Please list any medications that your child is **currently** taking. Please include vitamins, over the counter and herbal remedies:

Name of Medication	Strength	When Started	How Many Times a Day

Please list any medications your child has taken in **the past**, *except* for antibiotics and decongestants:

Name of Medication	Reason Prescribed	Strength	When Started	Child's Response

Has your child ever had: any of the following problems?

Head-banging	Yes	No
Hair-twirling	Yes	No
Hand-flapping	Yes	No
Twirling	Yes	No
Twitches or eye blinks	Yes	No
Throat clearing	Yes	No
Excessive worries or fears	Yes	No
Worried about dirt or germs	Yes	No
Needs to carry out certain rituals	Yes	No
Feels he or she has to be perfect	Yes	No
Likes things to be very neat and clean	Yes	No
Argues a lot	Yes	No
Does not carry out requests	Yes	No
Sad, unhappy, depressed	Yes	No
Irritable	Yes	No
Hits other people	Yes	No
Many temper tantrums	Yes	No

Any other concerns that have not been listed? (*please describe*) ____________________

FAMILY HISTORY

Please provide information about the child's family.

Father

Age: Level of Education: Occupation:

Please describe any learning difficulties:

Mother

Age: Level of Education: Occupation:

Please describe any learning difficulties:

Siblings:

Name: Age: Grade in School:

Please describe any learning difficulties:

Name: Age: Grade in School:

Please describe any learning difficulties:

Name: Age: Grade in School:

Please describe any learning difficulties:

Name: Age: Grade in School:

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Name: Age: Grade in School:

Please describe any learning difficulties:

Name: Age: Grade in School:

Please describe any learning difficulties:

Please list and describe any medical conditions that run in the family (including thyroid disease, diabetes, elevated blood pressure, heart problems, and cancer).

Does any blood relative have any of the following issues:

	Yes	**No**	**Relationship to Child (i.e. Maternal Grandmother)**	**Description of Issue**
Anxiety				
Obsessions/Compulsions				
Panic				
Depression				
Bipolar Disorder				
Schizophrenia				
ADHD				
Impulsive, Risk-Taking Behavior				
History of Victimization or Trauma				
Drug or Alcohol Abuse				
Suicidal Behavior				
Tourette's Syndrome				
Psychiatric Hospitalization				
Emotional Difficulties				
Learning Problems				

Please list and describe any other psychiatric disorders possibly present in the child's family. Please include specific information about relation of individual and disorder:

SOCIAL HISTORY

Please list all the people living in your home:

Name	**Age**	**Relationship to Child**

How is your child around the house?

What things does your child enjoy doing?

What things does your child do well?

How does your child get along with siblings?

Please answer the following questions about your child's play activities:

	At What Age	Does Well	Has Trouble
Plays by him or her self			
Plays with other children			
Plays with dolls			
Plays with siblings			
Plays with imaginary friends			
Plays groups games			
Participates in sports activities			

Does your child get along well with other children?

How many close friends does your child have?

How often does your child play with other children?

Are the majority of your child's playmates:

Older than child *Younger than child* *Same Age as child*

What activities does your child do with his/her mother?

What activities does your child do with his/her father?

What are some of the discipline strategies practiced?

What chores or jobs does your child have around the house (keeping room clean, cleaning out dishwasher, taking out trash, caring for pets, etc)? Please rate how well these activities are performed.

Chores/Responsibilities	Needs Constant Reminding	Sometimes does them	Almost always does them

Please describe your child's TV watching habits:

TV Program	Is the show watched daily?	When (what time)?

Please write out a daily (including Saturday and Sunday) schedule indicating when your child gets up, eats breakfast, leaves for school, attends after school activities, plays, watches TV, eats dinner, gets ready for bed, and goes to sleep.

MONDAY

Time	**Activity**

TUESDAY

Time	**Activity**

WEDNESDAY

Time	**Activity**

THURSDAY

Time	**Activity**

FRIDAY

Time	Activity

SATURDAY

Time	Activity

SUNDAY

Time	Activity

Please describe the sports your child enjoys and how he/she compares with his/her peers:

Sport	Don't Know	Not as Good	Average	Above Average

Are there any aspects of the sports your child plays that appear to be particularly challenging to your child?

SENSORY HISTORY

Has your child ever done any of the following behaviors?

	Yes	No	Sometimes (if so, when?)
Avoids certain textures (sand, mud, foods, lotions, etc)			
Strongly dislikes having hair washed, combed or brushed			
Strongly dislikes having dirty hands			
Has trouble tolerating touching, hugging or cuddling			
Strongly dislikes having hair or fingernails cut			
Prefers to wear only certain types of clothes			
Frequently runs into or accidentally bumps objects or people			
Seems unaware of cuts, bumps or bruises			
Frequently walks on tiptoes			
Crawled with arched or fisted hands			
Over sensitive to sound (puts hands over ears)			
Becomes easily distracted by environmental sounds			
Has difficulty following directions			
Frequently chews on clothes or objects			
Avoids eating certain types of textures or foods			
Seems overly sensitive to smells			
Seems unaware of smells and tastes			
Craves tangy or zesty food			
Get carsick frequently			
Avoid swinging, sliding or using playground equipment			
Seek out swinging			
Avoid trampolines			
Hold hands or body in unusual positions			

Has your child ever had any of the following problems?

	Yes	No	Sometimes (if so, when?)
Poor balance			
Poor Motor Coordination			
Uses too much or too little pressure with objects			
Avoids using vision to coordinate hand/body movements			
Has difficulty with puzzles, colors and shapes			
Blinks excessively when trying to catch balls or balloons			

Does your child have any other sensory input sensitivities to that have not been listed?

If yes, please describe them:

Has your child ever exhibited any of the following behaviors?

	Yes	No
Head-banging		
Hair-twirling		
Hand-flapping		
Twirling		
Twitches or excessive eye blinks		
Throat clearing		
Excessive worries or fears		
Worried about dirt or germs		
Needs to carry out certain rituals		
Feels he or she has to be perfect		
Likes things to be very neat and clean		
Argues a lot		
Does not carry out requests		
Sad, unhappy, depressed		
Irritable		
Hits other people		
Frequent temper tantrums		

Does your child seem to be more active, restless, or fidgety than other children?

If yes, when did you first notice this?

Does your child seem to be easily distracted and have trouble attending to chores, school work or TV?

If yes, when did this start?

Does your child have any other behaviors that have not been listed above?

If yes, please describe them:

PAST PSYCHIATRIC HISTORY

Has your child ever seen a psychiatrist?

If yes, please list him/her and give the dates seen:

Has your child ever seen a psychologist?

If yes, please list him/her and give the dates seen:

Has your child ever seen a therapist?

If yes, please list him/her and give the dates seen:

Has your child ever seen a speech/ language therapist?

If yes, please list him/her and give the dates seen:

Has your child ever seen an occupational therapist?

If yes, please list him/her and give the dates seen:

Has your child ever seen a neurologist?

If yes, please list him/her and give the dates seen:

Has your child ever seen a neuropsychologist?

If yes, please list him/her and give the dates seen:

Has your child ever been hospitalized for psychiatric reasons?

If yes, please describe the circumstances and give the dates of hospitalization:

Has your child ever had psychological testing?

If yes, please list the evaluator, the dates testing was done and the tests taken:

SCHOOL HISTORY

Please list all the schools that your child has attended (please include nursery/preschool, kindergarten, and all grades):

School Name and Grades attended	Dates Attended	Teacher Comments

Please list your child's current grades:

Class Name	Current Grade

Has your child ever repeated or skipped a grade?

If yes, please explain which grade and the reason:

Has your child ever been in a special class?

If yes, please explain what kind of class and the reason:

What is your child's best subject in school?

What is hardest for your child?

Does your child have any behavior problems in school?

If yes, please describe them:

How does your child get along with other children at school?

How does your child get along with his/her teacher(s)?

Do you feel that the school is dealing with your child's problems appropriately?

Please explain your answer:

Do you feel that the school is helping your child use his/her strengths appropriately?

Please explain your answer:

Do you maintain contact with the school?

Please explain your answer:

Please describe your child's ability to handle homework (if your child does not have homework, please draw a line through this section and move on to the next section):

Your child keeps track of his/her own assignments.

Don't know *Needs Constant Supervision* *Partially Independent*

Almost Completely Independent *Completely Independent*

Your child completes daily homework assignments on time.

Don't know *Needs Constant Supervision* *Partially Independent*

Almost Completely Independent *Completely Independent*

Your child turns daily homework assignments in on time.

Don't know *Needs Constant Supervision* *Partially Independent*

Almost Completely Independent *Completely Independent*

Your child plans and completes long-term projects, such as book reports, on time.

Don't know *Needs Constant Supervision* *Partially Independent*

Almost Completely Independent *Completely Independent*

Approximately how many hours a night does your child spend on homework?

Is getting homework done a source of stress in your family?

If yes, please describe:

Please comment on any of the above statements/questions or any other concerns you may have regarding school:

PROFESSIONALS CURRENTLY PROVIDING CARE

Please note, in order to assure confidentiality, contact will not be made without a completed *Authorization to Release/Request Information* signed by the child's parent/legal guardian (and by the child, if he/she is between the ages of 14 and 18).

Name	Care Provided	Telephone Number	Fax Number	E-mail Address