Dorogusker, Price & Associates

Developmental History Questionnaire

Confidential

Please complete this questionnaire as fully as possible. The information will be useful in addressing your concerns and evaluating your child.

Please type in the gray boxes. They will expand to allow as much room as you need.

Childs Name:	
Date of Birth	
Address 1	
Address 2	
City, State, Zip	
Home Phone	
Cell Phone	
Parents E-mail address	
In Case of Emergency	

School	
Teachers Name	
School phone number	
Current Grade	

Referred by	

Name of person filling out this form	
Today's Date:	

Current Concerns

Primary reason for this referral ☐

Describe the primary concerns that led you to request this appointment. ☐

When did these problems first appear and how persistent have they been? ☐

Is your child aware of your concerns? Yes ☐ No ☐

If so, how would she/he describe the problem? ☐

Have you alerted the school about this evaluation? Yes ☐ No ☐

Is there anyone I should contact regarding this evaluation prior to testing? ☐

1 Lenox Place
Maplewood, New Jersey 07040

10 Fairmount Avenue
Chatham, New Jersey 07928

32 Gramercy Park South #1B
New York, New York 10003

973-763-8375
Fax: 973-701-1449

Family and Home

Father	
Date of Birth	
Last Grade Completed	
Occupation	
Employer	
History of learning disabilities, depression, substance abuse (please explain)	
Years of schooling	
Biological father	☐ Yes ☐ No

Mother	
Date of Birth	
Last Grade Completed	
Occupation	
Employer	
History of learning disabilities, depression, substance abuse (please explain)	
Years of schooling	
Biological mother	☐ Yes ☐ No

Siblings

Name	Gender	Birth Date	Age	Grade	Learning, health or emotional problems?
	M ☐ F ☐				
	M ☐ F ☐				
	M ☐ F ☐				
	M ☐ F ☐				
	M ☐ F ☐				

Others Living in the Household

Have any members of the family needed assistance or been delayed in reading, spelling, math, or speech?	☐ Yes ☐ No
Please describe	
Who cares for the child in the parents' absence?	
Languages spoken at home	
What other language(s) does the child hear, speak, or understand at home?	
If English is not the first language, when did s/he learn to speak it?	
Has the child ever been separated from the parents for any length of time?	

Is the family currently ☐ Intact ☐ Single parent ☐ Divorced ☐ Remarried ☐ Blended
If single or divorced, is the child living with ☐ Mother ☐ Father ☐ Shared custody

Is your child adopted? Yes ☐ No ☐ If so, give age at time of adoption. ☐

Family Medical History

If you are not the biological parents, please answer the following section as best as you can regarding the biological parent's health, school achievement or delays, possible learning or emotional disturbance, speech or language problems, vision or hearing, and ages.

☐ Alcoholism	☐ Epilepsy
☐ Allergies	☐ Heart disease
☐ Anxiety	☐ Hypertension
☐ Asthma	☐ Learning disabilities
☐ Attention/concentration problems	☐ Mental retardation
☐ Cancer	☐ TB
☐ Depression	☐ Thyroid
☐ Diabetes	☐ Other mental illness
	☐ Other medical conditions

Please explain any items checked: ☐

Biological parents educational background (if you are not the biological father or mother)

Father

Last Grade Completed	
History of learning disabilities, depression, substance abuse (please explain)	
Years of schooling	

Mother

Last Grade Completed	
history of learning disabilities, depression, substance abuse (please explain)	
Years of schooling	

Pregnancy

Describe mother's general condition during pregnancy (include any complications):

☐

Biological mothers age at delivery ☐

During pregnancy was there any:

☐ Toxemia	☐ German measles
☐ Eclampsia	☐ Injuries
☐ Rh factor incompatibility	☐ X-ray studies
☐ Bleeding during first three months	☐ Other

Indicate the use and frequency of any of the following substances during pregnancy

	Frequency
☐ Beer or wine	
☐ Hard liquor	
☐ Coffee or other caffeinated beverages (Coke, etc.)	
☐ Cigarettes	
☐ Other	

Indicate the use and frequency of any of the following medications during pregnancy

	Frequency
☐ Valium (Librium, Xanax)	
☐ Tranquilizers	
☐ Anti-seizure medications (e.g. Dilatin)	
☐ Antidepressants	
☐ Treatment of diabetes	
☐ Antibiotics	
☐ Sleeping pills	
☐ Other (please specify)	

Prenatal History. Please explain as necessary

Describe labor. Indicate type of delivery (normal, breech, Caesarian, forceps, induced). Describe any problems.

☐

Describe the child's condition at birth (APGAR scores, etc.)

☐

Were there any indications of fetal distress during labor or delivery? Yes ☐ No ☐

Was the child born on or about the expected date? Yes ☐ No ☐

Weight at birth	
Any problems during hospital stay	Yes ☐ No ☐
Feeding difficulties	Yes ☐ No ☐
Jaundice	Yes ☐ No ☐
Infection	Yes ☐ No ☐
Seizures	Yes ☐ No ☐
Please explain any checked items	
Was a newborn screen done	Yes ☐ No ☐
Results	

Infancy, describe your child as an infant

Was this an "easy" or "difficult" baby?	
Response to touch	
Response to cuddling	
Describe your child's eating behavior.	
Was the child colicky?	
Describe your child's sleeping pattern including naps and sleeping at night.	
Describe your child's responsiveness (alertness).	
How did the baby behave with other people (sociability)?	
How persistent/insistent was your baby when s/he wanted something?	

Describe the ease or difficulty your child had in establishing routines (e.g. predictable patterns of eating, sleeping, etc.)

☐

Describe your child's activity level as an infant/toddler.

Problems during the first year?

☐ Incubator	☐ Meningitis
☐ convulsions	☐ slow weight gain
☐ injury high fevers (104+)	☐ bowel problems
☐ frequent ear infections	☐ difficulty swallowing or sucking
☐ breathing difficulties	☐ difficulty eating
☐ infections	☐ Other

Please explain any checked items

Do you have any concerns about alcohol or drug use with this child? Yes ☐ No ☐
Please explain

Developmental Milestones

Note the age when these emerged and any unusual details.

	Age	Relative Timing	Comment
Smile		○ Early ○ On Time ○ Late	
Roll over		○ Early ○ On Time ○ Late	
Sit up unsupported		○ Early ○ On Time ○ Late	
Crawl		○ Early ○ On Time ○ Late	
Walk		○ Early ○ On Time ○ Late	
Grasp objects		○ Early ○ On Time ○ Late	
Bladder trained		○ Early ○ On Time ○ Late	
Bowel trained		○ Early ○ On Time ○ Late	

In the **infancy-toddler period**, were any of the following present to a *significant degree*?

☐ Was not calmed by being held and stroked	☐ Very unpredictable appetite
☐ Colic	☐ Picky eater
☐ Did not enjoy cuddling	☐ Temper tantrums
☐ Excessive restlessness	☐ Difficulties in being comforted or consoled
☐ Diminished sleep because of restlessness and easy arousal	☐ Unwillingness to go along with change in daily routine
☐ Frequent head banging	☐ Shyness with strangers
☐ Constantly into everything	☐ Looseness of floppiness
☐ Excessive number of accidents compared to other children	☐ Tendency to twitch or jerk arms or head often
☐ Very unpredictable length of sleep	

Please explain any checked items above

Have there been any important events (e.g. moving, divorce, accidents, illnesses, deaths) in your family that have affected your child? Yes ☐ No ☐

If so please explain

How do you feel they affected your child?

What has been the most difficult adjustment in your child's life to date?

Medical History

Describe your child's general health?

Describe your child's hearing and note date of the last hearing test.

Describe your child's vision and note date of the last eye examination.

Is your child color blind?	Yes ☐ No ☐
Has you child ever been seen by a dentist?	Yes ☐ No ☐
Results or current treatment	
Has your child ever received psychiatric care?	Yes ☐ No ☐
Name of doctor	
When	
Why	
Results?	
Has your child ever had a lead screening done?	Yes ☐ No ☐
Results?	
Has your child had any chronic health problems (e.g. asthma, diabetes, heart condition)?	Yes ☐ No ☐
If yes, please describe	

Please note any of the following illnesses your child may have had and at what age

	Age	Comment
☐ Allergies		
☐ Chicken pox		
☐ Encephalitis		
☐ Lead poisoning		
☐ Measles		
☐ Mumps		
☐ Otitis media		
☐ Pneumonia		
☐ Scarlet fever		
☐ Seizures		
☐ Whooping cough		
☐ Other		

Describe any accidents or falls your child has had.

Did any of these result in any of the following conditions: Please note dates.

	Date	Comment
☐ Broken bones		
☐ Severe lacerations		
☐ Head injury		
☐ Severe bruises		
☐ Stomach pumped		
☐ Eye injury		
☐ Dental injury		
☐ Stitches		
☐ Other		

Describe any hospitalizations or surgery your child may have had.

What as your child like as a toddler? (For instance, was he/she quiet, easy-going, clingy, independent, impulsive, enthusiastic, defiant, negative)?

Problem Check List

Please check any areas in which your child currently has difficulty now

☐ Attention/concentration	☐ Persistent worries
☐ Bed wetting	☐ Physical complaints
☐ Depressed mood	☐ Relationships with peers
☐ Eating	☐ Sexual development
☐ Fears	☐ Sleeping
☐ Learning weaknesses	☐ Temper outbursts
☐ Nervous habits	☐ Toilet training
☐ Nightmares	☐ Other

Please explain any items checked:

Sleep:

How many hours per night, on average, does your child sleep?	
Does your child have difficulty falling asleep?	Yes ☐ No ☐ Sometimes ☐
Is your child a restless sleeper? _____	Yes ☐ No ☐ Sometimes ☐
Does your child kick his/her legs while sleeping?	Yes ☐ No ☐ Sometimes ☐
Does your child snore?	Yes ☐ No ☐ Sometimes ☐
Does your child appear to have difficulty breathing while asleep?	Yes ☐ No ☐ Sometimes ☐
Does your child stop breathing while sleeping?	Yes ☐ No ☐ Sometimes ☐
Does your child exhibit daytime sleepiness?	Yes ☐ No ☐ Sometimes ☐
Does your child fall asleep while at school?	Yes ☐ No ☐ Sometimes ☐
Does your child have nighttime terrors or nightmares?	Yes ☐ No ☐ Sometimes ☐
Does your child sleep walk?	Yes ☐ No ☐ Sometimes ☐
Is your child able to sleep alone in his/her own bed?	Yes ☐ No ☐ Usually ☐
If no please explain:	
(For younger children): Does your child bed wet? _	Yes ☐ No ☐ Sometimes ☐
Does your child nap in the afternoon after school?	Yes ☐ No ☐ Sometimes ☐
(For adolescents?) How late does your child sleep on the weekends?	

Language

Describe your child's speech and language?

At what age did your child begin to understand spoken words?	○ Early ○ On Time ○ Late
When did your child say his/her first word?	
At what age did your child begin combining two and three words together?	
At what age could s/he name colors	
Did strangers understand your child's early language?	Yes ☐ No ☐
Does your child have difficulty organizing and expressing his/her ideas?	Yes ☐ No ☐
Can he/she retell a story in a logical order?	Yes ☐ No ☐

Does your child

Constantly request that information be repeated	Yes ☐ No ☐
Have difficulties hearing similarities/differences between sounds	Yes ☐ No ☐
Has trouble learning phonetically	Yes ☐ No ☐
Has trouble following multi-step directions	Yes ☐ No ☐
Often says “What?” or seems to need clarification	Yes ☐ No ☐
Has an aversion to loud sounds	Yes ☐ No ☐

Please rate your child on the following using a scale of 1 - 4.
1 (very poor), 2 (below average), 3 (average), 4 (above average).

Speaking clearly	1 ☐ 2 ☐ 3 ☐ 4 ☐
Understanding jokes and stories	1 ☐ 2 ☐ 3 ☐ 4 ☐
Understanding non-verbal communication (for example, facial disapproval)	1 ☐ 2 ☐ 3 ☐ 4 ☐
Telling stories	1 ☐ 2 ☐ 3 ☐ 4 ☐

Describe any other developmental concerns:	

Motor Skills

Rate your child on the following skills

	Poor	Average	Good	Outstanding
Gross Motor Skills				
Walking	☐	☐	☐	☐
Running	☐	☐	☐	☐
Throwing	☐	☐	☐	☐
Catching	☐	☐	☐	☐
Fine Motor Skills				
Buttoning	☐	☐	☐	☐
Shoelace tying	☐	☐	☐	☐
Writing	☐	☐	☐	☐
Copying from board	☐	☐	☐	☐
Handling small objects	☐	☐	☐	☐
Cutting / tracing	☐	☐	☐	☐
Holding utensils properly	☐	☐	☐	☐

Do you consider your child to be athletic?	☐ Yes ☐ No
Where does s/he excel or have difficulty?	

Please rate your child on the following using a scale of 1 - 4.

Remembering where to find things	1 ☐ 2 ☐ 3 ☐ 4 ☐
Building things	1 ☐ 2 ☐ 3 ☐ 4 ☐
Drawing/art work	1 ☐ 2 ☐ 3 ☐ 4 ☐
Balancing/dancing	1 ☐ 2 ☐ 3 ☐ 4 ☐
Finding his or her way around (versus getting lost)	1 ☐ 2 ☐ 3 ☐ 4 ☐
Recognizing faces	1 ☐ 2 ☐ 3 ☐ 4 ☐

Is your child tactile sensitive?	Yes ☐ No ☐

How does your child’s motor development compare to others the same age? (faster or slower or the same	☐ Faster ☐ Slower ☐ Same

Does your child have any unusual difficulties with the skills of daily life (for example, getting dressed, crossing the street)? Yes ☐ No ☐

If so, please describe: ☐

Is your child left or right handed or ambidextrous? ☐ Left ☐ Right ☐ Ambidextrous
At what age did you first notice a hand preference? ☐

Social Skills

Does your child seek friendships with peers?	Yes ☐ No ☐
Do others seek your child out for friendship?	Yes ☐ No ☐
Does your child play and get along with other children?	Yes ☐ No ☐
How easily does your child make friends?	
Do those relationships tend to last?	Yes ☐ No ☐
Briefly describe any problems your child has with peers	
Describe your child's sensitivity and concern for the feelings of others	
Does your child have many friends: Are they the same age, older or younger: How does he/she generally get along with them?	

Home Behavior and Environment

Does your child engage in imaginative play? (Such as make believe games, pretending and acting out)	Yes ☐ No ☐
At what age did this begin?	
How does your child spend time after school?	
What are special hobbies/interests?	
Is your child difficult to discipline?	Yes ☐ No ☐
What is your child like at home? (Include activity level, ability to play alone, relations with siblings).	
What are your child's interests, skills, hobbies? Does your child like participating in sports? What games does he/she like to play?	
How much time, on an average weekday, does your child spend watching television,	
Playing a video/computer game or involved with some other computer activity (e.g. instant messaging)?	
What about on the weekend?	

Does your child exhibit:

Hyperactivity (high activity, more than average motion)	Yes ☐ No ☐
Poor attention span	Yes ☐ No ☐
Impulsivity (poor self control)	Yes ☐ No ☐
Low frustration threshold	Yes ☐ No ☐
Sloppy table manners	Yes ☐ No ☐
Interrupts frequently	Yes ☐ No ☐
Doesn't listen when being spoken to	Yes ☐ No ☐
Sudden outbursts of physical aggression toward others	Yes ☐ No ☐
Easily become distracted by environmental sounds (like trains going by)	Yes ☐ No ☐
Acts like s/he is being driven by a motor	Yes ☐ No ☐
Wears out shoes more frequently than siblings	Yes ☐ No ☐
Heedless to danger	Yes ☐ No ☐
Excessive number of accidents	Yes ☐ No ☐
Doesn't learn from experience	Yes ☐ No ☐

Poor memory	Yes ☐ No ☐
More active than siblings	Yes ☐ No ☐
Changes moods quickly	Yes ☐ No ☐
Gets bossed easily by other children	Yes ☐ No ☐
Becomes fixated or obsessed with objects or ideas	Yes ☐ No ☐

Please explain any checked items:

When you need to set clear limits for your child or when they have not abided by family rules, what strategies have you found to be effective?

Treatment History

Has you child ever been referred for or received any of the following?

	Grade	Describe Results
☐ Educational evaluation		
☐ Speech & language evaluation		
☐ Psychological evaluation		
☐ Neuropsychological evaluation		
☐ Psychological services		
☐ Occupational therapy		
☐ Physical therapy		
☐ Tutoring		

School & Educational History:

What are your current educational concerns?	
When was a problem first noticed?	
What have you been told about this/these problems?	
How do you think that I/we might be able to help you?	
What have you said to your child about this evaluation	
What questions do you have?	

At what age did your child begin Kindergarten?	

School History

Schools attended. Please list chronologically stating where and when. Also include teacher names and phone numbers (for us to contact if needed). Include day care and pre-school.

School	Grades	Town	Telephone

Has school generally been a positive or negative experience? What have his/her grades been like? Please explain.

Has your child ever been retained?	Yes ☐ No ☐
If so when, when and what grades	
Did your child have any separation difficulty?	Yes ☐ No ☐
Was school attendance ever interrupted for more than 20 days?	Yes ☐ No ☐
Has your child ever been classified?	
What was the classification (i.e. “Specific Learning Disability,” “Reading.” Etc.	
If so, in what grade was the classification?	
Was he or she ever declassified?	
In what grade was she/he declassified	
Were special services ever recommended and received?	Yes ☐ No ☐
Is your child currently classified?	Yes ☐ No ☐

Please explain any “yes” answers above

Does your child complete homework readily? Yes ☐ No ☐
Approximately how long per day does s/he spend on homework?
Does s/he do homework independently? Yes ☐ No ☐

Please check any *significant* problems reported by the classroom teacher.

☐	Doesn’t sit in seat
☐	Frequently gets up and walks around the class
☐	Shouts out. Doesn’t wait to be called on
☐	Doesn’t wait his or her turn
☐	Doesn’t cooperate in group situations
☐	Does better in one to one relationships
☐	Doesn’t respect the rights of others
☐	Doesn’t pay attention

Please explain checked items:

Favorite subjects:

Least favorite subjects:

School Experience

Generally describe your child’s overall adjustment to school, services received in school, general performance, and any strengths and weaknesses during each of the following time periods.

Preschool:

Kindergarten:

Grades 1-3:

Grades 4-6: ☐

Junior School: ☐

High School: ☐

Describe any academic subjects which have been especially difficult for your child.
☐

Has you child ever been evaluated by a Child Study Team? Yes ☐ No ☐
Was classification recommended or was he/she eligible for a 504 accommodation plan? Yes ☐ No ☐

If yes, please explain
☐

What accommodations, if any, were instituted, and were they helpful?
☐

Has your child ever received any type of services (e.g. learning disabilities class, resource room, speech therapy, occupational therapy)? Yes ☐ No ☐

Please describe the type of service and duration.
☐

Specific Academic Areas

Reading

Do you believe that your child has a reading problem? Yes ☐ No ☐

What method was used to teach him or her in school? (For example, Whole Language or Phonics based method)
☐

What strategies does s/he use to read? (For example, looking at pictures, sounding out words)
☐

Does s/he read for pleasure? Yes ☐ No ☐
If so, what types of books? ☐

Check any items that you've noticed your child having difficulty with to a *significant* degree.

☐ Remembering sounds of letters	☐ Easily bored
☐ Remembering names of letters	☐ Only reads for a short while
☐ Keeping place when reading	☐ Trouble understanding what is read
☐ Figuring out new words	☐ Trouble remembering what is read
☐ Tries to sound everything out	☐ Reads too fast
☐ Dislikes small print	☐ Fluency
☐ Reads below grade level	☐ Accuracy

Does your child

Have difficulty discriminating between	
Letters *b* and *d*	Yes ☐ No ☐
Short words like *on* or *no*	Yes ☐ No ☐
Longer words like *through, though*	Yes ☐ No ☐
Makes reversal errors in:	
Letters like *b* and *d*, *n* and *u*	Yes ☐ No ☐
Words like *saw* and *was*	Yes ☐ No ☐
Reads from right to left	Yes ☐ No ☐
Hold head close to the paper for reading/writing	Yes ☐ No ☐
Have trouble remembering words just seen in the text	Yes ☐ No ☐
Skip lines when reading	Yes ☐ No ☐
Please explain any checked "yes"	

Math

Circle any items that you've noticed your child having difficulty with to a *significant* degree.

- ☐ Math tests
- ☐ Math concepts
- ☐ Remembering math facts
- ☐ Abstract reasoning
- ☐ Lining up numbers correctly
- ☐ Telling time
- ☐ Word problems
- ☐ Knowing the value of coins and making change

Spelling and Writing

Check any items that you've noticed your child having difficulty with to a *significant* degree.

☐ Spelling	☐ Organizing thoughts
☐ Leaves off word endings	☐ Avoids writing
☐ Editing work	☐ Poor handwriting
☐ Sentence fragments	☐ Rushes through writing assignments
☐ Run on sentences	☐ Note taking
☐ Grammatically correct sentences	☐ Getting ideas

Has your child worked with a word processor?	☐ Yes ☐ No
Are his or her key boarding skills poor, adequate or superior?	
Is s/he able to complete homework assignments using the computer?	☐ Yes ☐ No

Organization and Study Skills

Check any items that you've noticed your child having difficulty with to a *significant* degree.

☐ Outlining	☐ Studying for tests
☐ Losing things	☐ Test anxiety
☐ Planning ahead	☐ Completing assignments
☐ Working independently	☐ Bringing assignments to school
☐ Keeping notebooks, book bag and desk organized	☐ Writing down assignments
	☐ Memorizing

Strengths

Describe your child's strengths. What are the things you are most proud of?

Describe your child's affinities (things he/she likes to do or learn about. For example, acting, bike riding, playing with animals, music, sports, fixing or repairing things, etc.):

In what areas would you like to see him/her grow stronger? What are your goals?

Please bring copies of school report cards, previous evaluations, school standardized tests, work samples or any other helpful material to our first meeting