



Triangle Psychological Services
Integrating Psychology and Faith

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Date Form Completed: _____
 Name of person(s) completing this form: _____

DEVELOPMENTAL QUESTIONNAIRE

Child Name: _____ M F Birthdates: _____
 Home Ph. #: _____ S.S.#: _____
 Address: _____

 Grade: _____ School: _____ Ph.# _____
 Any special placement this year: _____
 Teacher: _____ Principal: _____
 Address: _____
 PCP/Practice: _____ Ph. #: _____
 Address: _____

FAMILY INFORMATION: (If living with someone other than parent, please specify)

Parent/Guardian's Name: _____ Relationship: _____ DOB: _____
 S.S.# _____ Home Ph.: _____ Cell: _____
 Occupation: _____ Employer: _____
 Address: _____
 Marital Status: _____ Date of Current Marriage: _____
 Spouse's Name: _____ S.S.#: _____ DOB: _____
 Does this parent live with child? Y N If no, describe visitation/contact if any:

Parent/Guardian's Name: _____ Relationship: _____ DOB: _____
 S.S.# _____ Home Ph.: _____ Cell: _____
 Occupation: _____ Employer: _____
 Address: _____
 Marital Status: _____ Date of Current Marriage: _____
 Spouse's Name: _____ S.S.#: _____ DOB: _____
 Does this parent live with child? Y N If no, describe visitation/contact if any:

Person Responsible for Payment: _____ Relationship to
 child: _____
 Is there a child custody court order? Y N If yes, provide
 details: _____

Who referred you to this practice: _____

If a thank you is appropriate, please provide their address & phone #: _____

— Do you agree with this referral? Y N Mixed Feelings

If no, why? _____

Who is primary caregiver in the home? _____

Please list any other people who care for your child a significant amount of time (e.g., grandparent, neighbor, etc): _____

—

Briefly describe your child/adolescent:

Reason you are bringing your child/adolescent for this appointment:

Behavioral/emotional concerns & symptoms:

Has your child/adolescent experienced any significant losses/changes not already described? Please explain:

Family Background

Is child/adolescent adopted? Y N If yes, at what age & date? _____ From
where? _____

Household Members:

Name	DOB	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Members Residing Elsewhere:

Name: _____ Phone #: _____
Address: _____

Name: _____ Phone #: _____
Address: _____

Name: _____ Phone #: _____
Address: _____

Name: _____ Phone #: _____
Address: _____

Parental Marital Status

Mother: Single _____ Married & date(s) _____
If separated or divorced, please give date & any relevant information:

If deceased, please give date & relevant information:

Father: Single _____ Married & date(s) _____

If separated or divorced, please give date & any relevant information:

If deceased, please give date & relevant information:

Please list religious affiliation(s)/spiritual connections of parents & child/adolescent:

If either parent has experienced any significant losses in their lifetime please explain:

If child/adolescent was adopted, please give any relevant information about biological parent history:

Has anyone in the child/adolescent's and parents' families ever previously seen a therapist? If so, at what age(s)? Whom did you or they see and for what reason? How long was the treatment? Was the experience helpful? (Use the back of this page if necessary.)

Was anyone in your family ever hospitalized for emotional problems?

Birth and Toddler History

Were there any illnesses/complications during the pregnancy with this child/adolescent?

Circle all items related to biological mother that occurred during her pregnancy with this child/adolescent:

Smoking

Drinking alcohol

Marijuana use

Drug use

Domestic violence

Major illnesses

Physical injury

Prenatal care

Death of significant other

Total number of pregnancies of biological mother: _____

Were there any miscarriages? _____ Please explain circumstance(s):

Which pregnancy was this child/adolescent? _____

Nature of delivery: Full term _____ Premature _____ Cesarean _____

How would you characterize the experience?

Baby's birth weight: _____ Height: _____

Were there any complications during labor and/or delivery? (Circle: breathing problems, cord around neck, color, jaundice, other) Please explain:

Did baby have any complications/problems immediately after birth?

Did the baby have colic and/or feeding problems during the first three months?

How was the baby fed?

Was her/his appetite usually good?

Excessive thumb sucking _____

Excessive masturbation _____

Hurting self _____

Sleep problems _____

Nightmares _____

Bedwetting _____

Excessive fears _____

Excessive fantasizing _____

Intentionally hurting others _____

Problems going to school _____

Problems making friends _____

How does this child/adolescent compare with her/his siblings?

During the infant/toddler years, did either parent stay home full or part time? Please explain.

Who was the primary caretaker of the child/adolescent at home?

Did your child/adolescent attend preschool and/or daycare? Ages? Part-time or fulltime:

School History

(If your child/adolescent is home schooled please disregard.)

Schools Attended:

Elementary: _____

Junior High: _____

High School: _____

Any skipped grades: _____ What grade(s): _____

Any repeated grades: _____ What grade (s): _____

Favorite subjects: _____

Difficult subjects: _____

Has your child/adolescent attended any gifted and talented classes? Y N If so, please list:

Has your child/adolescent participated in special education classes? If so, please describe the type of services provided, and what categories your child/adolescent was placed in:

What has been your child/adolescent's emotional experience while placed in these programs?

Medical/Mental Health History

Current pediatrician's name: _____

Address and Phone Number: _____

When was your child/adolescent's last complete physical? _____

Any allergies? _____

Any special physical problems? Please explain.

Medical Problems

Related Medications

Has your child/adolescent had any serious accidents/injuries/illnesses involving such things as (circle); convulsions, high fevers, loss of consciousness, fainting, headaches, chronic fatigue, head injuries, ear problems, meningitis, other:

Did your child/adolescent ever require hospitalization? If so, please explain:

Has your child/adolescent ever been evaluated by a psychologist privately or through the school system? If so, when, and by whom?
What do you remember of the evaluation results/recommendations?

Previous Mental Health Services

Service	Provider	Ph. #

What was the outcome of these services and what was your child/adolescent's experience? Explain each separately please.

Any past or current history of medications prescriptions for emotional/behavioral problems? Please list and explain the effectiveness of the medication below.

Has your child/adolescent ever been molested? If so, when and by whom? How did you find out and what action,

if any, did you take? What was your child/adolescent's experience of this action?

Has your child/adolescent had any abuse prevention/assertiveness training?_____

Would you be interested in further information? Yes_____No_____

About Your Child/Adolescent

List any significant life traumas:

List any significant life influences:

How would you characterize your child/adolescent's relationship(s) with her/his sibling(s)?
What is your child/adolescent's relationship like with you?

Whom is the child/adolescent most like, in your family? How?

Who are the people your child/adolescent tells secrets, worries, feelings to, in your family?

What discipline methods have you found to be most effective with your child/adolescent?

What are your child/adolescent's favorite activities?

What are your child/adolescent's least favorite activities?

In what after school activities does s/he participate?

Please list any chores or jobs your child/adolescent has at home (e.g., babysitting, mowing the lawn, dishes, laundry, etc):

How well does your child/adolescent carry out the above chores?

What are your main concerns about your child/adolescent?

What kind of help do you expect from me in working with your child/adolescent?