CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's Name: _____ **Date of Birth:** _____ **Age:** _____ **Grade:** _____

Person providing information: _____ **Relationship to child:** _____

Who does child live with (please check one): ☐ Both Parents ☐ Mother ☐ Father ☐ Other (specify) _____

Biological Father's Name: _____ **Occupation:** _____ **Years education:** _____

Biological Mother's Name: _____ **Occupation:** _____ **Years education:** _____

***If applicable,* Guardian's Name** _____ **Occupation:** _____ **Years education:** _____

Primary Language of Caretaker: _____ **Primary Language of Child:** _____

Are biological parents of child currently: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

• If separated or divorced, who has *legal* custody? ☐ Mother ☐ Father ☐ Other (specify) _____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

_____

Are there other adults who have a *significant* part in raising your child? ☐ Yes ☐ No

• If yes, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.) _____

_____

Who currently lives with the patient? Attach additional sheets as needed.

Name	Age	Relationship	Occupation/Grade

What do you feel are your child's strengths? _____

What do you feel are your child's weaknesses? _____

What are your current concerns about the patient? What prompted you to seek services?

Concern	When concern developed

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is your child: ☐ Biological Child ☐ Adopted Child ☐ Foster Child ☐ Other (specify) _____

Mother's age at birth? _____ **Did mother receive routine medical prenatal care?** ☐ Yes ☐ No

List any prescription medications, alcohol, nicotine or drugs taken during pregnancy: _____

_____

Please check the conditions below that describe the health of the child and mother:

Mothers Pregnancy	Child's Delivery	Child's Condition at Birth
☐ No complications	☐ Normal	☐ Normal
☐ Blackouts	☐ Induced labor	☐ Lack of oxygen
☐ Falls	☐ C-section	☐ Breathing problem
☐ Physical injury	☐ Breech birth	☐ Birth injury/defect
☐ Excessive bleeding	☐ Unusually long labor (>12 hours)	☐ Jaundice
☐ Hypertension	☐ Premature # of weeks _____	☐ Premature # of weeks _____
☐ Diabetes	☐ Overdue # of weeks _____	☐ ICU # of days _____
☐ Emotional stress	☐ Other problem (specify)	☐ Other problem (specify)
☐ Toxemia		
☐ Alcohol and/or drug use		
☐ Use of tobacco		
☐ Other problem (specify)		

Was the child considered full term? ☐ Yes ☐ No **If no, how many weeks?** _____

Child's birth weight: _____ pounds _____ ounces

How long was the child in the hospital after delivery? _____

List any interventions required for the child after birth (phototherapy, oxygen, etc.): _____

Did the child's mother or other primary caretaker experience depression or anxiety in the first two years of the child's life? ☐ Yes ☐ No

***If applicable,* Adoption History**

Was the Patient adopted? ☐ Yes ☐ No *(if no, skip to "B. Health History")*

Where was the child born? _____ **At what age was the child adopted?** _____

How many home placements/homes has the child had in his/her lifetime? _____

Is the child aware that he/she is adopted? ☐ Yes ☐ No

Does the child have contact with his/her biological mother and/or father? ☐ Yes ☐ No

B. Health History

Describe the state of your child's current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child currently taking any medication? ☐ Yes ☐ No

• If yes, please list medications and uses: _____

_____

Has your child had any of the following?

Please check all that apply.	Please describe and give details, dates, and/or age of onset
☐ Allergies	
☐ Appetite Changes	
☐ Asthma	
☐ Bedwetting	
☐ Emergency Room Visits	
☐ Head Injury	
☐ Hearing Problems	
☐ History of Ear Infections	
☐ Hospitalizations	
☐ Loss of Consciousness	
☐ Respiratory Disease	
☐ Seizures	
☐ Sleep Difficulties	
☐ Surgery	
☐ Thyroid Problems	
☐ Vision Problems	
☐ Other (please specify) _____	

C. Developmental Milestones

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat without support	☐	☐	☐	☐	☐	☐	☐	
Crawled	☐	☐	☐	☐	☐	☐	☐	
Walked alone	☐	☐	☐	☐	☐	☐	☐	
Walked up stairs	☐	☐	☐	☐	☐	☐	☐	
Spoke first word	☐	☐	☐	☐	☐	☐	☐	
Spoke 2-3 word phrases	☐	☐	☐	☐	☐	☐	☐	
Spoke in sentences	☐	☐	☐	☐	☐	☐	☐	
Fully bladder trained	☐	☐	☐	☐	☐	☐	☐	
Fully bowel trained	☐	☐	☐	☐	☐	☐	☐	
Stayed dry all night	☐	☐	☐	☐	☐	☐	☐	

Child's current level of speech: ☐ No Words ☐ Few Words (<10) ☐ 2-3 word phrases daily ☐ Fluent speech

Have you ever been concerned that your child lost skills after meeting certain milestones (that is, lost speech, eye contact, motor skills, etc.)? ☐ Yes ☐ No

• If yes, please explain: _____

_____

D. Child Mental Health History

Has your child been diagnosed with any of the following? (Please check all that apply)

Diagnosis	When Diagnosed	By Whom
☐ Alcohol Addiction or Abuse		
☐ Anorexia		
☐ Anxiety		
☐ Attention Deficit-Hyperactivity Disorder (ADHD)		
☐ Autism Spectrum Disorder		
☐ Bipolar Disorder		
☐ Conduct Disorder		
☐ Depression		
☐ Developmental Delay		
☐ Drug Addition or Abuse		
☐ Intellectual Disability		
☐ Learning Difficulties (reading, math, writing, spelling, etc.)		
☐ Obsessive Compulsive Disorder		
☐ Oppositional Defiant Disorder		
☐ Schizophrenia		
☐ School Failure (failing grades, dropout, etc.)		
☐ Speech or Language problem (articulation, stuttering, etc.)		
☐ Tic Disorder		
☐ Other (please specify): _____		

Has your child ever received psychological counseling? ☐ Yes ☐ No

• If yes, by whom (professional/agency) and when: _____

_____

Has your child ever received speech, occupational, physical, vision, or other therapies? ☐ Yes ☐ No

• If yes, what services, by whom (professional/agency), and when: _____

_____

Has your child ever participated in educational services from a private entity (i.e., private tutor)? ☐ Yes ☐ No

• If yes, by whom (professional/agency) and when: _____

_____

Has your child ever participated in an early intervention program? ☐ Yes ☐ No

• If yes, by whom (professional/agency) and when: _____

_____

To your knowledge, has your child (check all that apply):

Please check all that apply.	**Please give details, dates, and/or age of onset**
☐ Used or abused alcohol?	
☐ Used/abused drugs (prescription or illegal)	
☐ Injured him/herself on purpose	
☐ Attempted suicide	
☐ Talked about wanting to be dead	
☐ Threatened to hurt others	
☐ Been the victim of violence or aggression	
☐ Been the victim of bullying	
☐ Been abused (sexual, physical or emotional)	
☐ Harmed animals	

Additional Notes/Comments: _____

_____

Please note any legal or criminal history: _____

_____

III. FAMILY INFORMATION

A. Family Mental Health History

Does anyone in the child's family have a history of the following? (Please check all that apply)

Diagnosis	Father	Mother	Sibling	Grand-parent	Aunt/Uncle/ Cousin
Alcohol Addiction or Abuse	☐	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	☐
Antisocial Personality Disorder	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Attention Deficit-Hyperactivity Disorder (ADHD)	☐	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐
Borderline Personality Disorder	☐	☐	☐	☐	☐
Conduct Disorder	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐
Drug Addition or Abuse	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐
Learning Difficulties (reading, math, writing, spelling, etc.)	☐	☐	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐
Oppositional Defiant Disorder	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
School Failure (failing grades, dropout, etc.)	☐	☐	☐	☐	☐
Speech or Language problem (articulation, stuttering, etc.)	☐	☐	☐	☐	☐
Tic Disorder	☐	☐	☐	☐	☐
Other (please specify): _____	☐	☐	☐	☐	☐

Additional Notes/Comments: _____

_____

B. Family Stressors

Have any of the following things occurred in the family?

Event	Month, Year	Description
☐ Chronic illness		
☐ Death of loved one		
☐ Divorce or Separation		
☐ Financial Difficulties		
☐ Job Loss		
☐ Move		
☐ Other (please specify): _____		

IV. EDUCATIONAL HISTORY

What school does your child attend? _____

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? □ Not a struggle □ Sometimes a struggle □ Often struggles

Has your child ever:

Please check all that apply.	Please give details, dates, and/or age of onset
☐ Repeated a grade or been held back?	
☐ Been expelled or suspended?	
☐ Missed more than 10 days of school in one school year?	
☐ Had an IEP (special education) or Section 504 Plan?	
☐ Had a significant decline in grades?	
☐ Been diagnosed with a learning disability?	
☐ Received extra support at school?	
☐ Been identified as gifted/talented?	
☐ Other (please specify): _____	

V. BEHAVIOR

A. Behavior in Infancy

During your child's first *few years of life*, were any of the following present to *significant* degree? (Check all that apply)

- ☐ Did not enjoy cuddling
- ☐ Was not easily calmed by being held or being stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Frequent head banging
- ☐ Difficult nursing
- ☐ Poor eye contact
- ☐ Did not turn towards caregivers
- ☐ Did not respond to name
- ☐ Did not respond to speech of caregivers
- ☐ Fascination with certain objects
- ☐ Constantly into everything

Please describe all checked items: _____

_____

_____

B. Current Home Behavior

How would you describe your child's personality at home? _____

How does your child get along with brothers/sisters? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior at home? (e.g., talking, time-out, grounding, etc.) _____

How does your child respond to discipline? _____

List any responsibilities your child has at home: _____

Indicate child's… Bed time ____:____PM **Wake time** ____:____ AM **Does child sleep well?** ☐ Yes ☐ No

How much time does your child typically spend on electronics (computer, video games) each day? _____

Have any family members expressed concerns about your child's behavior? ☐ Yes ☐ No

• If yes, please explain: _____

E. Social Behavior:

Does your child get along well with other children in the neighborhood? ☐ Yes ☐ No

• If no, please explain: _____

Describe your child's peer relationships and choice of friends? (i.e., how many friends? What age/genders?) ____

_____

Does your child tend to be: ☐ Shy ☐ Outgoing ☐ A Leader ☐ A Follower ☐ Other (please specify) _____