San Luis Obispo County
MENTAL HEALTH SERVICES
2178 Johnson Avenue
San Luis Obispo CA 93401-4535

Child's name: _____
Form completed by: _____
Date: _____

Developmental History Questionnaire

Please complete as fully as possible

Pregnancy:

Mother's age when child was born: _____
Mother's general attitude toward the pregnancy: _____
Father's general attitude toward the pregnancy: _____
Any major family or couple stressors or conflicts about the pregnancy? If yes, please describe. _____
_____
Mother's general health during pregnancy with this child: _____
Did mother receive prenatal care from a doctor? _____
Did mother use any of the following during pregnancy: □ Alcohol □ Tobacco □ Marijuana
□ Cocaine □ Heroin/methadone □ Psychiatric medication □ Anti-seizure medication
□ Methamphetamine □ Antibiotics □ Sleep medications □ Other _____
If yes, please describe the amount, frequency, and at what point in the pregnancy the substances were used:
_____
Were there any other concerns or problems with the pregnancy? _____

Birth: Infant was:
□ full term (born on schedule) □ premature (if so, how early ____) □ overdue (if so, how late ____)
Delivery was: □ normal/vaginal □ induced □ planned C-section
□ emergency C-section due to _____ How long was labor? _____
Were there any complications with the delivery? _____
Did infant have any of the following: □ wrapped cord □ lack of oxygen □ positive drug screen
□ other injury or problem _____
Infant's birth weight: _____ Height: _____
How long did mother remain in the hospital? _____How long did infant remain in the hospital? _____
Who did infant go home from the hospital with? _____
Did the infant have any feeding problems (allergies, difficulty keeping food down, colic, etc.)? _____
If yes, please describe: _____
Did the infant have any sleep problems or schedule problems? _____
If yes, please describe: _____
Does the child still have sleep or schedule problems? _____ If yes, please describe: _____

Milestones: at about what age did the child begin to: crawl_____ walk _____
Say individual words _____ Say first sentence _____ toilet trained (bladder)_____
(bowel) _____ Comments: _____
Has the child ever been evaluated or served by TriCounties Regional Center? _____
If yes, please describe: _____
Preschool: If old enough, did child attend: □ preschool □ Head Start □ Child Development Center
□ Other: If so, where, for how long, and how did child do? _____
If in school now, did the child seem ready to start kindergarten? _____
If not, please describe concerns: _____

Social: Is your child able to make friends easily? _____ If not, please describe concerns: _____
_____
Does your child keep friends for long?_____ If not, please describe concerns _____
Do you have any concerns about the child's social skills or friendships? _____
_____

Developmental History Questionnaire

Client Name: _____ Client Number _____

Personality: Check each box that best describes your child in his/her first five years.

Activity Level: How active was your child?

□High	□ Medium	□ Low
□ always on the go □ wouldn't sit still □ restless, "squirmy" □ other:	□ active □ moved about as much as much as most kids □ other:	□ quiet □ moved very little □ could sit for extended periods □ other:

Persistence: How well did your child 'stick with it'?

□High	□ Medium	□ Low
□continued to work when frustrated □ refused to accept "no" □other:	□ Between high and low	□ very easily frustrated □ gave up easily □ accepted "no" easily □ other:

Adaptability: How well did your child handle changes?

□High	□ Medium	□ Low
□ adapted well to changes □ switched activities easily □ settled for naps or bed easily □ had a number of interests □ other:	□ Between high and low	□ upset by changes in routine □ switched activities with great difficulty □ settled for naps or bed with great difficulty □ had only a few interests, but was extremely focused on them □ other:

Sensitivity: How sensitive was your child to sights, sounds, textures, movement?

□High	□ Medium	□ Low
□ disliked being touched or held □ startled easily or seemed bothered by loud sounds □ strong dislike of play involving movement (spinning, swinging, etc.) □ often complained about clothes itching or not feeling right □ very picky eater – bothered by food texture or spices □ other:	□ Between high and low	□ cuddly, sought out touch □ not bothered by loud sounds □ strongly preferred play involving movement (spinning, swinging, etc.) □ no difficulty with clothes □ would eat whatever adults were eating □ other:

Intensity: How strong were your child's emotional reactions?

□High	□ Medium	□ Low
□ fussy □ frequent major tantrums □ upsets lasted longer than expected □ lots of drama □ other:	□ Between high and low	□ calm □ easily comforted □ got over upsets quickly □ settled self easily □ other:

Response to caregiver: How did your child respond to you?

□High	□ Medium	□ Low
□ curious/happy □ eager for interaction with with caregiver/playful □ very upset when caregiver left □ followed directions readily □ other:	□ Between high and low	□ stiff/avoided eye gaze □ not interested in interaction/play with caregiver or very aloof □ more interested in things than in people □ refused to listen or follow rules □ other:

Independence: How well did your child play or work on his/her own?

□High	□ Medium	□ Low
□ curious/liked to explore □ able to entertain self □ other:	□ Between high and low	□ timid or not willing to try new things □ needed constant attention □ other:

Do you have any other concerns about your child's behavior or development? _____

_____

Staff Signature: _____ Date: _____

Client Name: _____ Client Number _____