Military Healthcare OVERSEAS

DEVELOPMENTAL HISTORY QUESTIONNAIRE

Name of Child: _____ Date of Birth:_____

This form completed by:_____Date:_____

FAMILY HISTORY

Mother's Name:_____Date of Birth:_____

Occupation:_____Highest Level of Education:_____

Father's Name:_____Date of Birth:_____

Occupation:_____Highest Level of Education:_____

Parent's current marital status:

Single____ Married____ Divorced____ Separated____ Widowed____ Remarried____

How long?_____

Child lives with: Both Parents _____ Mother_____ Father_____ Other_____

Please list all people in child's immediate family:

Name	Relationship to child	Age/ Grade	Living in the house?

Military Healthcare OVERSEAS

Please list all other non-family members who live in household:

Name	Relationship to child / family	Age / Grade

Please List all locations (city, state) that your child has lived:

1. Birthplace _____

2. _____ Moved at age/grade _____

3. _____ Moved at age/ grade _____

4. _____ Moved at age/ grade _____

What is the primary language spoken in the home?_____

Is there a family history of the following?
☐ Learning Difficulties (reading, math, writing)
☐ Speech or Language problem (stuttering, etc.)
☐ Developmental Disorder (such as Autism, etc.)
☐ Emotional Problems (depression, mood swings, etc.)
☐ Intellectual Disability/Mental Retardation
☐ School Failure (failing grades, dropout, etc.)
☐ Drug or Alcohol Addiction

Military Healthcare OVERSEAS

MEDICAL HISTORY

Pregnancy:

Mother's health during pregnancy:_____

Length of Pregnancy:_____ Any illnesses or complications during pregnancy?

Explain:_____

_____

_____

List any prescribed medications:_____

Smoking/drug/alcohol use by mother or father?_____

Delivery: _____Full Term ____ Premature _____Natural _____Caesarean _____Breech

_____Fetal Distress _____Forceps Labor: Hours____

Medications used, if any:_____

Birth weight: ____lbs, ____ozs.

Any complications?_____

Mother's Pregnancy	**Child's delivery**	**Child's condition at birth**
☐ No Complication ☐ Blackouts ☐ Falls ☐ Physical Injury ☐ Excessive Bleeding Hypertension ☐ Diabetes ☐ Emotional Stress ☐ Toxemia ☐ Drug/Alcohol use ☐ Use of Tobacco ☐ Postpartum Depression	☐ Normal ☐ Induced Labor ☐ C-Section ☐ Breech Birth ☐ Unusually long labor(>12h) ☐ Premature #____ Weeks ☐ Overdue #_____ Weeks ☐ Other problem, Specify: _____	☐ Normal/No Problems ☐ Lack of Oxygen ☐ Breathing Problems ☐ Birth Injury / Defect ☐ Jaundice ☐ Newborn ICU #____Days ☐ Other problem, Specify: _____

Early Development: Who was the primary caregiver?_____

Did your child have any feeding problems such as allergies to milk or formula, or messiness?_____

Baby's behavior (e.g. crying, eating, sleeping):_____

_____

Milestones generally achieved: Early _____ Typical _____

Any concerns with speech development?

Explain._____

_____

Age toilet training begun_____

Completed_____Accidents_____

When did your child begin trying to dress and undress by him/herself?_____

At what age did your child begin to sleep alone in own bed?_____

Any concerns about sleep?_____

_____

Military Healthcare OVERSEAS

Please indicate the age or age range when your child performed the following milestones:

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Sat up without help	☐	☐	☐	☐	☐	☐	☐
Crawled	☐	☐	☐	☐	☐	☐	☐
Walked	☐	☐	☐	☐	☐	☐	☐
Spoke first words	☐	☐	☐	☐	☐	☐	☐
Spoke sentences	☐	☐	☐	☐	☐	☐	☐
Fully potty trained	☐	☐	☐	☐	☐	☐	☐
Stayed dry all night	☐	☐	☐	☐	☐	☐	☐

Medical Information:

Please indicate the approximate number of times your child had the following illnesses:

___ Asthma	___ Wax Build-up
___ Epilepsy	___ Fever over 102
___ Chicken Pox	___ Bronchitis
___ Croup	___ Seizures/Convulsions
___ Ear Infections	___ Lead Poisoning
___ Ear Infections	___ Pneumonia
___ Rheumatic Fever	___ Tonsillitis
___ Problem with adenoids	___ Loss of Consciousness

Has your child ever had: Tubes in his or her ears?

When_____ Which ear(s)?_____

Does your child tend to breathe through his or her mouth?_____

Any bumps to the head or loss of consciousness? _____

Any other serious illnesses or injuries?:_____

Military Healthcare OVERSEAS

Any surgeries or hospitalizations? When?_____

Why?_____

_____

Does your child complain of these symptoms more frequently than others his or her age. (Please check all that apply to your child)

☐ Indigestion ☐ Stomachaches Nightmares ☐ Sleepwalking ☐ Constipation ☐ Aches and pains Bedwetting ☐ Nail Biting ☐ Seems overactive Colds ☐ Thumb-sucking Vomiting ☐ Gets overly tired	☐ Nervous habits/tics ☐ Sinus trouble ☐ Headaches ☐ Difficulty sleeping ☐ Excessive perspiration ☐ Easily upset ☐ Diarrhea ☐ Difficulty chewing/ ☐ swallowing/eating Soiling (bowel accidents) ☐ Dizzy Spells

Is your child taking any medication?: __Yes __No. Please list and indicate for what condition:

Medication name	Taking from (date)	Dosage	Condition

My child last had a screening for: Vision: When_____

Results:_____

If your child wears glasses, when first prescribed?_____
Hearing: When_____
Results:_____

Military Healthcare OVERSEAS

EDUCATIONAL INFORMATION

Please list schools and grades attended at each:

_____

_____

Has your child ever had any problems with: ___Adjustment ___Behavior ___Learning

Please explain_____

_____

_____

Has your child participated in early intervention?

Explain._____

Has your child ever repeated a grade?

When?_____Why?_____

_____

Favorite subject?_____

Less favorite subject?_____

Has your child ever received a speech, educational or psychological evaluation? _____

What services?_____

When?_____

For what concerns?_____

_____

_ Is there any other information that would be helpful in understanding your child's needs?

_____

_____

_____

_____

_____

Military Healthcare OVERSEAS

SOCIAL RELATIONSHIPS

Does your child have difficulty keeping friends?_____

_____

How does your child get along with:

Parents:_____

Brothers and/or Sisters:_____

Teachers:_____

Other adults:_____

How does your child respond to discipline?_____

Are there any home, family, or social concerns of which we should be aware?_____

What are your child's areas of special interest or talent?_____

_____

What are your child's favorite activities?_____

_____

What do you like best about your child?_____

_____

What are your child's strengths?_____

_____

Thank you for taking the time to complete this form!