



Pediatric & Family
Psychology, P.A.

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DEVELOPMENTAL QUESTIONNAIRE

General Information

Child's Name: _____

Age: _____ Sex: _____ Date of Birth: _____

Current Grade: _____ Is your child home schooled? _____

Does your child attend Public or Private School? _____

Was your child adopted? _____ If yes, at what age? _____

Mother's Name: _____ Educational Level: _____

Current Work: _____

Father's Name: _____ Educational Level: _____

Current Work: _____

Brothers/Sisters:

Name	Biological? Yes/No (Explain)	Living at Home? Yes/No	Age	Sex	Grade
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Please list all other people living in your child's home:

Name	Age	Relationship to Child	Health/Problems
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Please list any other people who care for your child for a significant amount of time (e.g., grandparent, neighbor, etc.):

Please list religious affiliation/spiritual connection(s) of parents/child:

Parental Status

If partnered, for how long: _____ If married, on what date: _____

If separated or divorced, please give date(s) and on the back of this page explain the circumstances, custody & visitation schedule (if any) and communication status between parents. Additionally, please attach a copy of the custody order.

If a parent is deceased, please give the date and explain the circumstances:

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

Briefly describe your child:

Birth and Toddler History (If adopted, please answer to the best of your knowledge)

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

Total number of pregnancies: _____

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

How does this child compare with her/his siblings?

During the infant/toddler years, did either parent stay home full or part time?
If so, please elaborate on the circumstances.

During the infant/toddler years, did either parent stay home full or part time?
If so, please elaborate on the circumstances.

At what age did the child go to day care? What type of situation was this?
(e.g., home, day care center, etc.) How many hours per week?

Did your child have a toddler or young child history of emotional or behavioral
difficulties, such as (please circle):

head banging, breath holding, day soiling, excessive temper, tantrums, irritability, obsessive
thoughts, compulsive need to count things or touch them, overly aggressive behavior, or diffi-
culty controlling her/his impulses?

Approximately when did this start?

Did your child ever...	Age Began	Still Occurring
Hurt him or herself:	_____	_____
Have excessive sleep problems (either getting to sleep, going to sleep, nightmares or night terrors)?	_____	_____
Have excessive bedwetting difficulties?	_____	_____
Exhibit excessive fears?	_____	_____
Exhibit excessive fantasizing?	_____	_____
Intentionally hurt others?	_____	_____
Have problems going to school?	_____	_____
Exhibit difficulty paying attention or concentrating?	_____	_____
Exhibit frequent mood changes?	_____	_____
Exhibit motivational problems?	_____	_____
Have difficulty with substance abuse?	_____	_____

Other (please explain):

Developmental Milestones:

Age at which your child _____ sat up alone _____ crawled _____ began saying a few words
 _____ began walking _____ spoke in short sentences _____ laughed _____ played alone
 _____ began toilet training _____ ended toilet training _____ fed him/herself

School History (If your child 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 attended any gifted and talented classes? _____

If so, please list:

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

Medical/Mental Health History

Has your child had any serious accidents/injuries/illnesses involving such things as (circle): Convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, meningitis? Please explain:

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

Current Pediatrician's name: _____

Address and Phone Number: _____

When was your child's last complete physical?

Any special physical problems?

Is your child currently on medication: If so, please explain:

Does your child have any health problems at this time?

Has your child previously seen a therapist? If so, at what age(s)? Whom did s/he see: About how many meetings did the child/family have?

Has your child ever been evaluated by a psychologist privately or through the school system? If so, when, and by whom?

If so, what do you remember of the results/recommendations?

Has any member of your child's immediate family participated in mental health treatment? If so, please explain. (You may use back of page if needed).

Has your child ever been molested? If so, when and by whom?

Has your child had any abuse prevention/assertiveness training?

Would you be interested in further information? Yes _____ No _____

About Your Child

List any significant life traumas:

List any significant life influences:

How would you characterize your child's relationship with her/his siblings(s)?

Whom is the child most like, in your family?

In your family, with whom does your child share secrets, worries, feelings?

What discipline method(s) have you found to be most effective with your child?

What are your child's favorite activities?

Does your child participate in any after-school activities?

Please list any chores or jobs your child has at home (e.g., babysitting, making her/his bed, taking out the garbage, etc.):

How well does your child carry out the above chores?

What are your main concerns about your child?

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

Name of Person(s)
completing this form: _____

Date: _____