Integrative Wellness Therapy ®

The Whole-Person Method for Resilience and Wellness

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Developmental History Questionnaire

Today's date _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

Home phone #: _____ Cell phone #: _____

Who lives at home with the child? _____

School _____ Teacher: _____ Grade: _____

Reason for seeking screening and/or treatment _____

When did you first notice difficulties, and how were they apparent to you? _____

_____

Has the child received previous evaluation and/or treatment? _____

If so, where and with whom _____

PRENATAL HISTORY

Mother's age at birth of child: _____ Father's age at birth of child: _____

Were there any difficulties with conception, if yes please explain? _____

_____

Were there complications during pregnancy such as illness, bedrest, etc, if yes please explain?

_____

_____

Medications during pregnancy? _____

FAMILY HISTORY

Is there a family history of:

❑ Autism Spectrum Disorders ❑ Anxiety ❑ OCD

❑ Depression ❑ Genetic syndromes ❑ Learning Disabilities

❑ Substance Dependency ❑ Neurological Diagnoses ❑ Left-Handedness

If answered yes to any of the above, please explain _____

_____

BIRTH HISTORY

❑ Full term ❑ Premature (# of weeks) _____

❑ Normal birth ❑ Cesarean Birth ❑ Forceps used

❑ Prolonged labor (hours) _____ ❑ Short labor (hours) _____ ❑ Within normal

Medications during delivery?: _____

Apgar scores, if known: 1 minute _____ 5 minutes _____

Were there any complications such as:

❑ Breathing difficulty ❑ Jaundice ❑ Incubation

❑ Feeding difficulty ❑ Tube fed ❑ Transfusion

❑ Congenital defects ❑ Time in the NICU, if yes how long _____

Received Oxygen?: ❑ Intubated ❑ Just Oxygen How long? _____

Any additional information?: _____

_____

Was (is) your child breast fed, if yes for how long (months and weeks)? _____

Did (does) your child have difficulty breast-feeding, if yes please describe? _____

_____

Did (does) your child have difficulty using the bottle, if yes please describe? _____

_____

MEDICAL HISTORY

Has your child had any of the following, if yes please explain and give dates.

❑ Meningitis _____ ❑ High temperatures _____ ❑ Convulsions _____

❑ Measles _____ ❑ Whooping Cough _____ ❑ Mumps _____

❑ Chicken Pox _____ ❑ Scarlet Fever _____ ❑ Ear infections _____

❑ Allergies (please list) _____

_____

❑ Diet restrictions (please list) _____

_____

❑ Physical injuries (please describe and give dates) _____

_____

Does your child have any medical diagnoses? If yes, please explain: _____

_____

Is your child under a doctor's care for the above, if yes please provide name and phone number?

_____

Does your child take any medication regularly? If yes please list and state reason(s): _____

_____

_____

Has your child had a hearing test? If yes, give date, physician and results if possible: _____

_____

Has your child had an eye examination? _____ Does he/she wear glasses? _____

If yes, please give physician, date, and results if possible: _____

_____

DEVELOPMENTAL HISTORY

Give ages as near as possible:

Rolled over _____ Walked _____ Crawled _____

Sat alone _____ Talked (simple words) _____ Talked (sentences) _____

Check behaviors which describe your child as an infant:

❑ Cried a lot, fussy, irritable	❑ Resisted being held	❑ Drooled excessively
❑ Good, non-demanding	❑ Floppy when held	❑ Irregular sleep patterns
❑ Alert	❑ Tense when held	❑ Good sleep patterns
❑ Quiet or passive	❑ Very active	❑ Liked being held

SCHOOL PERFORMANCE INFORMATION

Please describe your child's:

Relationship with teacher: _____

Relationship with classmates: _____

Areas of academic difficulty: _____

_____

Areas of most success or enjoyment: _____

_____

Please list any academic test scores or levels if known: _____

_____

INTERESTS

Does your child have any hobbies, collections: _____

Does your child have any preferred characters, role models, actors: _____

What music does your child prefer: _____

What does your child prefer to do inside: _____

What does your child prefer to do outside: _____

What interests your child most: _____

When do you see your child most joyful or focused: _____