John A. Bartok, Ph.D., Ltd.
899 Skokie Blvd., Suite 424
Northbrook, IL 60062
(847 714-9492)

Please attach a recent picture of your child here.

Thank you.

Developmental Questionnaire

Child's Full Name _____ Date of Birth _____

Child's Age _____ Gender _____ Handedness _____

Child's Current Address _____ City _____

State _____ Zip Code_____ Home Phone _____

School _____ Grade _____

Is child adopted ? No _____ Yes _____ If yes, at what age? _____

Is child currently living with both birth parents? Yes_____ No_____

If no, with which parent is child living now? Father ___ Mother ___ Other (Specify): _____

Who has legal custody of the child: _____

Parent (1) name: _____ Date of Birth: _____

Cell/Work # _____ Email_____

Education _____ Occupation: _____

Parent (2) name _____ Date of Birth: _____

Cell/Work # _____ Email_____

Education _____ Occupation _____

Marital Status Mother _____ Father_____

Please list all brothers and sisters, and any other children living with the family:

Name	Age	Gender	Relationship to child

Please list all other adults living with the family:

Name	Age	Gender	Relationship to child

Who referred you to our service? Name: _____ Profession: _____

Address: _____Phone _____

What concerns do you have about your child and why are you seeking help for your child at this time?

_____

_____

_____

What kind of information or assistance are you hoping to obtain for your child? _____

_____

_____

Does the child have any school behavior problems? No _____ Yes_____ If Yes, please describe:

_____

_____

_____

Does the child have any learning or studying problems? No ____ Yes_____ If Yes, please describe:

_____

_____

_____

_____

Please describe any other problems your child may have that may be of relevance to this evaluation:

_____

_____

_____

Please describe two or three of the child's strengths:

_____

_____

Please describe two or three of the child's weaknesses:

_____

_____

Please list all past psychiatric, psychological, neurological, educational, speech, OT, or PT:

When	For What	By Whom

Please attach copies of the most recent report(s)

Please list all past or present interventions, treatment, or remediation (including Individual Therapy, CBT, PT, OT, Speech and Language, Educational Therapy, and/or Tutoring):

Type of Therapy	**When**	**By Whom**

Pregnancy and Birth History

Describe any difficulties in conception and/or complications that occurred during pregnancy:

_____

_____

Were any medications used during pregnancy? No_____ Yes_____ If yes, what kind?

_____

Was alcohol, or other substance, used during pregnancy? Describe frequency and type:

_____

Length of pregnancy: _____ weeks Length of labor: _____ hours

Birth weight: _____ lbs _____ oz Apgar score (if known): First: _____ Second: _____

Check any of the following complications that occurred during birth:

Forceps used: _____ Breech birth: _____ Labor induced: _____ Cesarean delivery _____

Other (Specify): _____

Were there any complications or difficulties during labor and the delivery?

_____

_____

What was the state of the infant's health at birth? ____

_____

Length of stay in hospital: Mother: _____ days Child: _____ days

Was your child in the NICU? No ____ Yes ____ Number of Days_____

Developmental History: Infancy (0-12 months)

Feeding problems? _____

Early infancy sleep difficulties? _____

Did your child respond to cuddling? _____

Was your child fussy, irritable? _____

Was your child overly active? _____

Was your child overly passive? _____

Was your child an easy baby? _____

Describe your child's temperament: _____

Any other noteworthy issues during infancy: _____

_____

Developmental Milestones: At what age did this child first do the following?

Domain:	Child did the following:	Age:	Problems, if any:
Motor	Sat without support		
	Crawled		
	Stood without support		
	Took first steps		
	Walked without assistance		
	Buttoned clothing		
	Tied shoelaces		
	Dressed self		
	Used a crayon		
	Rode tricycle		
	Rode bicycle (without training wheels)		
Toilet Training	Bowel trained		
	Bladder trained, day		
	Bladder trained, night		
Language	Babbled		
	Spoke first words besides "mama" & "dada"		
	Said three-word phrases		
	Spoke in complete sentences		
	Spoke clearly enough for strangers to understand		
	Could relate happenings well		
Play	Played with dolls/stuffed animals		
	Created and acted out stories		
	Played in cooperation with other children		

Developmental Problems:

Has this child experienced any of the following problems? If yes, please describe:

Type of Problem	**Description:**
Unclear speech	
Understanding language	
Repeating words or sentences he/she has heard	
Eating problems/ Food allergies	
Bed wetting	
Soiling	
Sleeping	
Current Bedtime/Wake time	
Sleep Walking	
Nail biting	
Thumb sucking	
Grinding teeth	
Tics and/or Twitches	
Head banging	
Rocking back and forth	
Impulsivity	
Aggressive behavior: e.g., biting, scratching, hitting, kicking	
Separating from parents	
Excessive crying or worrying	
Other problems:	

IV. Educational History:

Preschool: Did this child attend preschool? Yes No If yes, give name and location of the preschool:

_____

Between what ages? _____ Any problems in preschool? No_____ Yes_____

If yes, describe: _____

_____

Kindergarten: Did this child attend kindergarten? No_____ Yes_____ Full Day _____ Half Day _____

If yes, name and location: _____

At what age did the child enter kindergarten? _____

Did the child have problems separating? No_____ Yes_____ If yes, please describe: _____

_____

Any other problems in kindergarten? No_____ Yes_____ If yes, please describe: _____

_____

Elementary, Middle School, High School

List the names and locations of schools attended:

_____ Grades: _____

_____ Grades: _____

_____ Grades: _____

_____ Grades: _____

Name and address of current school: _____

_____

Teacher/ School Contact person's name:_____

Please indicate whether this child has had any of the following school experiences:

Age child entered 1st grade: _____

Has the child been retained a grade in school? If yes, when and why? _____

_____

Has the child skipped a grade in school? If yes, when and why? _____

_____

Does the child have difficulty with reading? If yes, describe: _____

_____

Does the child have difficulty with math? If yes, describe: _____

_____

Does the child have difficulty with writing or spelling? If yes, describe: _____

_____

Does your child have difficulty in other subjects or classes? If yes, describe: _____

_____

Has the child been placed in a special education/resource room class? If yes, describe:_____

_____

Does the child dislike going to school? If yes, describe: _____

_____

Current School Services or Placement (RTI, Section 504, or IEP):

LD: _____

ED/BD:_____

Speech & Language: _____

OT/PT: _____

Social Work/Counseling:_____

Family Medical History

Describe any family history of neurological, psychiatric or learning problems (Headaches, Seizures, ADHD, Depression, Bipolar Disorder, Schizophrenia, OCD, Panic Attacks, Anxiety, Alcohol/Substance Abuse):

_____

_____

_____

Please describe any other pertinent family medical history:

_____

_____

_____

Child's General Medical History

Please list and pertinent general medical history (surgeries, hospitalizations, recurrent infections, etc.):

_____

_____

_____

Neurological and Psychiatric History

Please list current medications and dose as well as any other medications taken for more than 3 months

Current:_____

Other:_____

Has your child ever experienced concussion, head injury, loss of consciousness, meningitis, encephalitis, stroke, sleep disorders, tumor, toxic metal exposure, headaches, seizures, tics, fainting, tremors? If so describe:

_____

_____

_____

Has your child been diagnosed with learning disabilities, dyslexia, ADD/ADHD, deficits, autism, Asperger syndrome, nonverbal LD, executive function/processing deficits, or Tourette syndrome,? If so, describe:

_____

_____

_____

Has your child used cigarettes, drugs, or alcohol? If so, please describe: _____

_____

Has your child been diagnosed or shown symptoms of emotional/behavior disorders (depression, bipolar disorder, cutting, suicidal thoughts, schizophrenia, phobias, panic attacks, anxiety, eating disorder, obsessive compulsive disorder, oppositional defiant disorder? If so, describe: _____

_____

_____

_____

Has your child been a victim of emotional, physical, or sexual abuse? If so, describe:

_____

_____

G. Socioemotional Development

Does the child have any problems at home? No_____ Yes_____ If yes, please describe: _____

_____

_____

_____

Does the child have any social problems with peers? No_____ Yes_____ If yes, please describe:

_____

_____

_____

_____

Does the child play with older, younger, or same age children? _____

Additional Comments:

_____

_____

_____

_____

Name of person(s) filling out this form: _____

Signature _____ Date_____

Relationship to child: Mother: _____ Father: _____ Other (Specify): _____