

**Couples and Family Wellness Center, LLC**  
**1034 Beaumont Road**  
**Berwyn, PA 19312**  
**610 889-2089**

**SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE**

**I. GENERAL INFORMATION**

Child's full name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Current Address: \_\_\_\_\_

How long at this address? \_\_\_\_\_

Who does child live with:  both parents  mother  father  other (specify) \_\_\_\_\_

Biological father \_\_\_\_\_ Occupation \_\_\_\_\_ Years education: \_\_\_\_\_

Father's home phone \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Biological mother \_\_\_\_\_ Occupation \_\_\_\_\_ Years education: \_\_\_\_\_

Mother's home phone \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

If applicable: Guardian's name \_\_\_\_\_ Occupation \_\_\_\_\_ Years education \_\_\_\_\_

Guardian's home phone \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Please list all people in child's immediate family: \_\_\_\_\_

\_\_\_\_\_  
Name Relationship to child Age / Grade Living in house? \_\_\_\_\_

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

\_\_\_\_\_  
Name Relationship to child/family How long has lived in household? \_\_\_\_\_

\_\_\_\_\_  
Are biological parents of child currently:  married  separated  divorced  never married

• If separated or divorced, who has *legal* custody?  mother  father  other (specify): \_\_\_\_\_

\_\_\_\_\_  
• If separated or divorced, how do you feel your child has adjusted to the separation/divorce? \_\_\_\_\_

\_\_\_\_\_  
Are there other adults who have a **significant** part in raising your child?  Yes  No

If so, please indicate name & relationship (stepparent, grandparent, boy/girlfriend, etc.) \_\_\_\_\_

\_\_\_\_\_  
Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc) \_\_\_\_\_

\_\_\_\_\_  
What do you feel are your child's...

Strengths \_\_\_\_\_

Weaknesses \_\_\_\_\_

Briefly describe your concerns for your child. \_\_\_\_\_

## II. HEALTH AND DEVELOPMENT

### A. Pregnancy and Birth

Is your child:  biological child  adopted child  foster child  other: \_\_\_\_\_

Mother's age at birth? \_\_\_\_\_ Did mother receive routine medical prenatal care?  Yes  No

Please specify any medications used during pregnancy and the reason used: \_\_\_\_\_

Pregnancy lasted \_\_\_\_\_ weeks / months Child's birth weight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

APGAR score ...at 1 minute \_\_\_\_\_ ...at 5 minutes \_\_\_\_\_  Unsure / Don't know

Did child go home from the hospital at the same time as the mother?  Yes  No

If No, explain why: \_\_\_\_\_

Please check the conditions below that describe the health of the child and mother during...

#### Mothers pregnancy

- No complications
- Blackouts
- Falls
- Physical injury
- Excessive bleeding
- Hypertension
  
- Diabetes
- Emotional stress
- Toxemia
- Alcohol and/or drug use
- Use of tobacco

#### Child's Delivery

- Normal
- Induced labor
- C-section
- Breech birth
- Unusually long labor (>12 hours)
- Premature # of weeks
  
- Overdue # of weeks
- Other problem (specify)

#### Child's Condition at Birth

- Normal
- Lack of oxygen
- Breathing problem
- Birth injury/defect
- Jaundice
- Newborn ICU # of days
  
- Other problem (specify)

### B. Health

Describe the state of your child's current health:  Excellent  Good  Fair  Poor

Is your child currently taking any medication?  Yes  No

If yes, please list medications and uses: \_\_\_\_\_

Has your child ever been identified as having a disability?  Yes  No

If so, by whom, what age, & what disability? \_\_\_\_\_

Has your child ever received psychological counseling?  Yes  No

If so, by whom (professional/agency) and when: \_\_\_\_\_

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc)?  Yes  No

If so, by whom (professional/agency) and when: \_\_\_\_\_

Has your child ever participated in educational services from a private entity (i.e., private tutor, Sylvan Learning Center)?  Yes  No

If so, by whom (professional/agency) and when: \_\_\_\_\_

Has your child ever participated in an early intervention program?  Yes  No

If so, by whom (professional/agency) and when: \_\_\_\_\_

Has your child had any of the following? Please check all that apply.	Please describe and give details, dates, and/or age of onset
<input type="checkbox"/> Serious Illnesses	
<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Surgery/Hospitalization	
<input type="checkbox"/> History of Ear Infections	
<input type="checkbox"/> Allergies and/or Asthma	
<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Frequent Nightmares and/or Bedwetting	
<input type="checkbox"/> Other health problem	

### **Family History**

Is there a <i>family history</i> for the following problems?	<i>Biological</i> family member with the history... (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
<input type="checkbox"/> Learning Difficulties (reading, math, writing, spelling)	
<input type="checkbox"/> Speech or Language problem (articulation, stuttering, etc.)	

<input type="checkbox"/> Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
<input type="checkbox"/> Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
<input type="checkbox"/> Intellectual Disability	
<input type="checkbox"/> School Failure (failing grades, dropout, etc)	
<input type="checkbox"/> Drug or Alcohol Addiction	

**C. Development**

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Crawled								
Walked alone								
Walked up Stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

**III. BEHAVIOR**

**A. Behavior in Infancy**

During your child's first *few years of life*, were any of the following present to *significant* degree?

- |   |  |
|---|--|
| <input type="checkbox"/> Did not enjoy cuddling                               | <input type="checkbox"/> Difficult nursing                       |
| <input type="checkbox"/> Was not easily calmed by being held or being stroked | <input type="checkbox"/> Poor eye contact                        |
| <input type="checkbox"/> Difficult to comfort                                 | <input type="checkbox"/> Did not turn towards caregivers         |
| <input type="checkbox"/> Colicky  | <input type="checkbox"/> Did not respond to name                 |
| <input type="checkbox"/> Excessive irritability                               | <input type="checkbox"/> Did not respond to speech of caregivers |

- Diminished sleep
- Fascination with certain objects
- Frequent head banging
- Constantly into everything

\* Please describe all checked items \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**B. Child's Early Temperament: (*Toddler through five years of age*)**

Activity Level – How active has your child been from an early age? \_\_\_\_\_  
 \_\_\_\_\_

Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks? \_\_\_\_\_  
 \_\_\_\_\_

Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way? \_\_\_\_\_  
 \_\_\_\_\_

Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)? \_\_\_\_\_  
 \_\_\_\_\_

Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? \_\_\_\_\_  
 \_\_\_\_\_

Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament? \_\_\_\_\_  
 \_\_\_\_\_

Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.? \_\_\_\_\_  
 \_\_\_\_\_

Prior to age six, did your child have more difficulty than other children his/her age...

- Sitting still at meal time
- Staying focused on TV, movies, or video games
- Paying attention when read to
- Waiting for a turn to play
- Throwing a ball
- Knowing left and right
- Catching a ball
- Acting without thinking
- Buttoning and zipping
- Dressing self
- Holding a crayon or pencil
- Tying shoe laces
- Accidentally dropping things
- Accidentally knocking things over

**C. Differential Behaviors**

Please check below all behaviors or characteristics that fit your child over the past year:

- Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- Often depressed/irritable mood
- Talks excessively, interrupts often, doesn't listen
- Often loses things, very disorganized compared to others his/her age.

- Low energy/fatigue
- Poor concentration
- Difficulty initiating tasks
- Difficulty completing tasks
- Difficulty following instructions
- Engages in impulsive behaviors (acts before thinking)
- Immature compared to peers
- Engages in physically dangerous activities
- Often argumentative with adults
- Often actively defiant to adult requests and rules
- Blames others for own mistakes
- Often angry or resentful
- Somatic complaints of not feeling well
- Excessive separation difficulties
- Easily frustrated
- Lies
- Steals
- Aggressive towards others
  - Adults
  - Peers
- Shy
- Feeling of worthlessness or low self-esteem
- Withdrawn
- Overly anxious or fearful
- Sleeping too little/insomnia
- Sleeping too much
- Difficulty making decisions
- Cries easily
- Temper tantrums
- Rapid mood changes/mood swings
- Suicidal thoughts
- Excessive need for reassurance
- Poor appetite
- Overeats
- Explosive temper with minimal provocation
- Odd fascinations
- Unrealistic worry about futures events
- Substance abuse
  - Drug
  - Alcohol
  - other

Please explain all checked items: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**D. Home Behavior:**

How often is each of the following settings a *problem* for your child?

While getting ready for school	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When eating at the dinner table	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When playing by him/herself	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When playing with siblings/other children	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When with a babysitter or daycare	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
In public places (church, store)	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When in the car	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When told to do something he/she doesn't want to do	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently

During sit-down homework time	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When watching TV or playing video games	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently

How would you describe your child's personality at home? \_\_\_\_\_

How does your child get along with brothers/sisters? \_\_\_\_\_

Which adult would your child prefer to talk with about a problem? \_\_\_\_\_

Who is the *family member* with whom your child feels closest? \_\_\_\_\_

Who is primarily responsible for discipline at home? \_\_\_\_\_

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.) \_\_\_\_\_

How does your child respond to discipline? \_\_\_\_\_

List any responsibilities your child has at home: \_\_\_\_\_

Does your child do these regularly? \_\_Yes \_\_ No

Does your child need frequent reminders? \_\_Yes \_\_ No

Indicate child's... Bed time? \_\_\_\_:\_\_\_\_PM Wake time? \_\_\_\_:\_\_\_\_ AM Does child sleep well? \_\_Yes \_\_ No

How much time does your child typically spend on electronic media? \_\_\_\_\_

Watching T V: \_\_\_\_hrs/day; Playing video/computer games: \_\_\_\_hrs/day; Other: \_\_\_\_\_ hrs/day

Have any family members expressed concerns about your child's behavior? \_\_Yes \_\_ No

Explain: \_\_\_\_\_

**E. Social Behavior:**

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?) \_\_\_\_\_

How does your child interact with children in the neighborhood? \_\_\_\_\_

**IV. Educational History**

How does your child feel about school? \_\_\_\_\_

How motivated do you feel your child is to learn? \_\_\_\_\_

About how much time does your child spend on homework each night? \_\_\_\_\_

How much of a struggle is homework?  Not a struggle  Sometimes a struggle  Often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)?  Yes  No

If yes, what services, when did they begin? \_\_\_\_\_

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare \_\_\_\_\_

Elementary School \_\_\_\_\_

\_\_\_\_\_

Middle School \_\_\_\_\_

\_\_\_\_\_

High School \_\_\_\_\_

\_\_\_\_\_