

Sandra Hawkins-Heitt, PsyD, PA

Clinical Psychologist

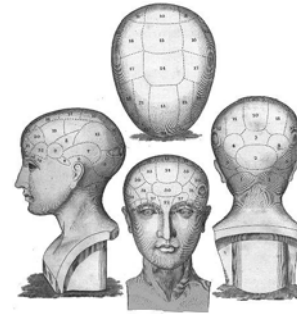
Executive Centre at Hooks Lane

8 Reservoir Circle, Suite 105

Baltimore, MD 21208

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CHILD DEVELOPMENT QUESTIONNAIRE

Patient		
Child's Name		
Address		Date of Birth
		Home Phone
School		
School Name		Phone
School Address		Teacher
		Grade
Pediatrician		
Pediatrician's Name		
Address		Phone
Mother		
Mother's Name		Date of Birth
Address		Home Phone
		Work Phone
Occupation		Cell Phone
Highest Education Completed		Other Contact
Father		
Father's Name		Date of Birth
Address		Home Phone
		Work Phone
Occupation		Cell Phone
Highest Education Completed		Other Contact
Family Members		
Other Family Members' Names	Relationship	Date of Birth
Parent/Guardian		
Parent's Marital Status <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Single		
If parents are not married, who has legal custody of child?		
<input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Mother & Father <input type="radio"/> Other (explain):		
<i>Please note that I require consent for treatment from both parents in joint custody situations.</i>		
How long married?	How long divorced?	Child's age at divorce?
Referral		
Please list the problems for which you want help for this child:		

What have you said to the child about this evaluation?

Whose idea was it that this child have an evaluation?

Treatment History

Has this child received any *evaluations* or any *treatment* prior to this contact such as psychological testing, counseling, psychiatric help, speech therapy, medications, special diets, etc.? Yes No (if yes, please describe below):

Date(s) of Treatment	Type of Treatment	Name/Contact Info of Treatment Provider

Medical History

Hospitalizations	Date(s) of Hospitalization	Facility Name/Contact Info

Medical Conditions

Medications	Dosage	Reason

Allergies

Family History

	Mother	Father	Brother(s)	Sister(s)	Others
Hyperactive as child					
Behavior problems					
In trouble as a teen					
Trouble learning to read					
Trouble learning to write					
Trouble with math					
Kept back in school					
Drug/Alcohol problems					

Birth History

Length of pregnancy (in months)

Illness/Complications during pregnancy? Yes No if yes, please explain:

Medications taken during pregnancy		
Substances taken during pregnancy	How much	How often
Cigarettes		
Alcohol		
Drugs	Type	
Did Father use substances during time of conception? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain:		
Were there any complications during labor and delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain:		
Did mother or baby stay in Special or Intensive Care following delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain:		
Developmental History		
Description of child as an infant (temperament, sleeping and eating patterns, etc)		
Milestones (age of accomplishment)		
<i>Gross Motor Skills</i>	<i>Fine Motor Skills</i>	<i>Language Development</i>
Crawled	Fed self with spoon	Single words
Walked alone	Scribbled	Used sentences
Sat by self	Tied shoes	(2+ words)
Ran well		Spoke clearly
<i>Potty trained:</i>		
Urine for day	Bowels for day	
Urine for night	Bowels for night	
Rate of development overall:	Slow	Normal Fast
Educational History		
Has this child been retained/held back in a grade? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain:		
Does this child receive any special education services? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please describe types of services and at what grade they began:		
Personality and Behavior		
Circle all traits that apply to your child now		
Sad	Happy	Leader
Quiet	Overactive	Independent
Fearful	Cooperative	Tantrums
Even-tempered	Loner	Social
		Anxious
		Compulsive
		Forgetful
Describe this child's strengths and interests		
Person Completing this Form		
Name	Relationship to Child	
Signature	Date	