Stevenson, Waplak & Associates

CLIENT DEVELOPMENTAL HISTORY

Date Submitted:

DOCTORS' REFERRAL QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

DEMOGRAPHICS

Patient's Name (last, first):	
☐ M ☐ F	DOB (mm/dd/yyyy):
Name of Parents:	
Family Heritage:	Religious Beliefs:
Family Doctor:	

REASON FOR REFERRAL

Chief Complaint (These would be the current areas of concern). Please check any that are appropriate:

BEHAVIOUR

	Physical Aggression		Verbal Aggression		Sexual Aggression
	Property Damage		Inattentive		Hyperactive
	Impulsive		Defiant		Other:

EMOTIONAL

	Depressed Mood		Suicidal Thoughts		Quick Emotional Fluctuations
	Increased Agitation		Sleep Changes		Excessive Changes In Energy
	Appetite Changes		Victim of Abuse – Explain:		

ACADEMIC

	Reading Difficulties		Spelling Difficulties		Math Difficulties
	Writing Difficulties		Speech Difficulties		Comprehension Difficulties

REASONING

	Overall Poor Educational Progress		Overall Poor Social Progress		
	Others/Comments:				

Describe a history of the identified difficulties and any current stressors:

PREVIOUS EVALUATIONS? Please check any that have occurred:				
	Family Doctor	Name	Date	Diagnosis
	Pediatric	Name	Date	Diagnosis
	Psychiatric	Name	Date	Diagnosis
	Psychological	Name	Date	Diagnosis
	School Board	Name	Date	Diagnosis
	Other	Name	Date	Diagnosis

Are there currently any other agencies involved in this client's care? Please check:					
	Children's Aid Society		Children's Mental Health		Mental Health Clinic
	Private Therapist		School Child & Youth Worker		Counselling Services of Belleville
	Probation		Court Proceedings		Other:
If involved may these agencies be contacted as part of providing care to this client?					
	Yes - a 'Form 14' will be provided to obtain and release information				
	No – please explain why:				

BIRTH PROCESS

Was the birth of this child…			
	Planned		Unplanned – Explain:
	Wanted		Unwanted – Explain:

What was the immediate and extended family's view of the pregnancy? Check all that apply.								
	Happy		Supportive		Concerned		Unsupportive		Other:

How did the mother feel physically during the pregnancy with this individual?			
	Healthy		Difficulties with:

Were any medications taken during the pregnancy?			
	No		Yes – Type and amount:

Any drugs or alcohol taken during the pregnancy?		No
	Alcohol – When and how much:	
	Drugs – When and how much:	

Did the mother smoke during the pregnancy?			
	No		Yes – When and how much:

Was it a full term pregnancy?		Yes		
	Premature – How many weeks:			Overdue – How many weeks:

How was the labour process? Check all that apply.					
	Short		Long		Easy
	Difficult – Comments				

Were there complications during the delivery?			
	No		Yes – comments:

How much did the baby weigh?	lbs	oz

INFANCY

How would you describe the emotional climate of the home when the baby arrived?

	Positive		Concerned		Negative

Comments:

Who was the primary caregiver?

	Mother		Father		Mother and Father		Other:

Please list other caregivers

	Mother		Father		Mother and Father		Other:

Was the baby a good eater?

	by Breast		by Bottle		Good Eater		Poor Eater

Comments:

What were the baby's early sleeping habits?

	Good Sleeper		Poor Sleeper	Comments:

Was the baby "cuddly"?

	Yes		No	Comments:

Was the baby "cuddly"?

	Yes		No	Comments:

Was the child comfortable with expressing and receiving affection?

	Yes		No	Comments:

What was the child's energy level?

	Low		Average		High

Comments:

Did the child enjoy exploring the environment?

	Yes		No	Comments:

Was there anything that the baby appeared to find over-stimulating? (e.g. noise, clothing, people)

	No		Yes	Comments:

Do you think that your child began to sit, stand, walk, talk unusually late or early?

	Low		Average		High

Comments:

CHILDHOOD

Any difficulties with toilet training?

	No		Yes	Comments:

Any bed wetting or soiling to follow?

	No		Yes	Comments:

Throughout childhood was there any discontinuity in the infant-mother relationship?

	No		Yes	Comments:

Did riding a bike and learning to tie their shoes develop at the right pace?

	Yes		No	Comments:

Has your child ever been ill? If so what was the illness, age of onset and treatment.

	No		Yes	Comments:

Any sensitivity to certain foods?											
	No		Yes	Comments:							
Any allergies? If so, to what and how is it treated.											
	No		Yes	Comments:							
Has your child had any serious accidents?											
	No		Yes	Comments:							
How would you describe the client's parent's relationship during his/her childhood?											
Comments:											
Were temper tantrums present that were out of the ordinary? If yes, what were they like.											
	No		Yes	Comments:							
Any difficulties with stuttering?											
	No		Yes	Comments:							
Any phobias? (Unusual fears?)											
	No		Yes	Comments:							
What was the child's reaction to discipline like?											
	Accepting		Passive		Defiant		Aggressive		Other:		
Comments:											
How would you describe the client's mother's and father's way of dealing with problematic behaviour?											
Mother		Passive		Assertive		Demanding		Aggressive		Other:	
Father		Passive		Assertive		Demanding		Aggressive		Other:	
Any disruptions in parental relationships through divorce, death or other causes?											
	No		Yes	Comments:							
Any tendencies for the client to be excessively independent or dependent?											
	Dependent		Independent	Mix							

ADOLESCENCE (Skip if child is currently younger- go to Family Section)									
Onset of signs of puberty?									
	10 yrs		11 yrs		12 yrs		13 yrs		14 yrs
The child's reaction to puberty?									
	Positive		Negative	Comments:					
How would describe the child's degree of impulse control? (How did they express anger, How did they handle sexual feelings?)									
	Good		Poor	Comments:					
What was the child's relationship with the family like during this period?									
	Good		Poor	Comments:					
What sort of peer group did the child possess? What quality of relationships did they form with both male and females?									
	Positive		Negative	Comments:					
	Just Males		Just Females		Both				
How did the child react to parental demands and standards?									
	Positive		Negative	Comments:					
Did any special gifts or talents emerge?									
	No		Yes	Comments:					

FAMILY

Who are the current people living in the house and the relationship to your child?

Does your child have any brothers or sisters? How old? How do they get along?

Is the parental dyad intact? (If a separation or divorce has occurred how old was the child? Was the separation easy or difficult? What type of things might the child have seen or heard during the relationship breakdown?)

Biological Mother - How would you describe yourself? What is your level of education? Any specific difficulties in school or specific likes or dislikes?

Biological Father - How would you describe yourself? What is your level of education? Any specific difficulties in school or specific likes or dislikes?

Step Parent - How would you describe yourself? What is your level of education? Any specific difficulties in school or specific likes or dislikes?

Any family history [any biological relatives] of medical or psychological difficulties? Please check all that apply.

	Depression	Who?
	Suicidal Thoughts	Who?
	Homicidal Thoughts	Who?
	Anxiety	Who?
	Alcoholism	Who?
	Drug Use	Who?
	Learning Disabilities	Who?
	Criminal Charges	Who?
	Personality Disorders	Who?
	Other	Who?
	Medical Conditions	Who? Type?

EDUCATIONAL

What was the earliest grade your child attended in school, including nursery school? How old was your child?

	Nursery School - 3 yrs		Jr. Kindergarten - 4 yrs		Sr. Kindergarten - 5 yrs		Grade 1 - 6 yrs

How did the child react?

	Positive		Negative	Comments:

Have any academic concerns developed? If so what and when?

	Reading		Spelling		Math		Writing		Comprehension
	Other								

Identified in:		JK		SK		Grade 1-2		Grade 3-4		Grade 5-6		Grade 7-8

Has your child had any behaviour problems at school? If so what and when did they start?

	Physical		Verbal		Sexual		Other

Identified in:		JK		SK		Grade 1-2		Grade 3-4		Grade 5-6		Grade 7-8

What does your child's report usually look like?

	Above Average		Average		Below Average		Barely Passing		Failing

Does the client receive any form of special assistance at school or outside of school to help their learning?

Does the client have an Educational Ministry Identification or Individual Education Plan? If identified what is the identification. If on an IEP what is the focus.

	No		Communications		Medical		Speech Impairment		Behavioural		Multiple

What is their current school and grade?

SOCIAL-EMOTIONAL

Does your child have many friends? Does s/he enjoy friends that are younger, older or the same age? Does the child participate in any organized group activities? If so, how do they do?

	Lots of Friends		Limited Friends		Same Age Friends		Younger Friends		Older Friends
	Does not participate in group activities				Participates in group activities:				

Has your child ever played with matches or fire?

	No		Yes	Comments:

How is your child around animals?

	Positive		Rough		Cruel		Comments:

Current sleep pattern. Please check any that apply.

	Delayed sleep onset. How long?		Nightmares		Repetitive awakenings
	Still tired in the morning		Lack of energy in the morning		No issues

Current eating pattern. Please check any that apply.

	Fluctuation in appetite		Recent weight loss		Recent weight gain		No issues

Are any unusual motor movements or sounds produced by the child?

	No		Yes	Comments:

Has your child recently had their hearing and vision tested?

Vision:		Yes (fine)		No		Uses or needs glasses
Hearing:		Yes (fine)		No		Identified problems

Has you child ever received medication? If so, what was it and what was the response.

	No		Yes	Comments:

Any current medications?

	No		Yes	Comments:

Who would you like the completed report to be shared with? (ie. Doctors)?

Thank you for your information.