Office Use:
Therapist: _______________
DOE: ____________
DOB: ____________
CA: ______________

Mile High Climbers
Supporting each child's unique climb.

Developmental Questionnaire

*This information needs to be completed **before** we are able to schedule an evaluation for your child. This information will be used to match the child's developmental level with the tasks administered in the evaluation.*

Client's Name:______________________ Client's Date of Birth (DOB):___________

Gender: ____________________ Race/Ethnicity:________________________

Current school: _____________________ Current Grade: _______________________

Child's Primary Care Physician:

Name:___________________________________ Phone: _______________________

Address:____

Permission to send evaluation report to physician? Yes No

Other Health Care Providers:

Name: ______________________Profession: ________________Phone: ________________

Name: ______________________Profession: ________________Phone: ________________

Name: ______________________Profession: ________________Phone: ________________

Contact Information:

Mother's Name:____

Address: ____

Daytime Phone: ________________________ Alt. Phone:___________________

Email: _______________________________

Father's Name:____

Address: ____

Daytime Phone: ________________________ Alt. Phone:___________________

Email: _______________________________

Primary Concerns:

__ Developmental Delay   __ Autism Spectrum Concerns   __Anxiety

__ Speech/Language Difficulties__ Sensory Difficulties   __Social Skills

__ Sleeping Problems   __ Behavioral Difficulties   __ Repetitive Behaviors

__ Impulsivity/Hyperactivity   __ Fine/Gross Motor Difficulties

__ Other concerns: ____

Please list any specific questions or concerns you would like addressed in this evaluation:________________________

____

Please identify a few of the client's strengths: ____

____

What are some of the client's interests? ____

____

PARENT INFORMATION

Are biological parents: □ Married/Partnered   □ Divorced/Separated

With whom does the client currently live? __________________________________

If the client does not currently live with biological/adopted parents, who has legal custody?

Mother's Education: Less than high school   High School or GED

College Degree   Graduate Degree

Current Occupation:____________________________________

Father's Education: Less than high school   High School or GED

College Degree   Graduate Degree

Current Occupation:____________________________________

If the client does not currently live with their biological parents:

Custodial Parent/Guardian's Name: _______________________________________

Address: ____

Phone Number: ______________________ (cell) ____________________________(work)
(Please indicate which number is best to reach you at during business hours)

FAMILY INFORMATION:

Does the client have siblings? □ Yes □ No (If yes, please provide details below)

Name	Biological? Y/N (Please explain)	Living at Home? Y/N	Age	Gender

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (e.g. parents, siblings, aunts, uncles or grandparents) Check all those that apply:

__ Allergies __ Deafness __ Nervousness/Anxiety

__ Learning Difficulties __ Glandular problems __ Perceptual Motor Disorder

__ Speech/Language __ Seizures __ Developmental Delay

__ ADHD __ Autism Spectrum Disorder __ Asperger's

__ Nonverbal Learning Disability __ Rett's Disorder

__ Childhood Disintegrative Disorder __ Sensory Processing Disorder

__ Mental Illness

__ Other: ____

CHILDHOOD HISTORY

Is your child adopted? Yes No

If yes, please indicate the age you assumed care of your child: _____________________

Please indicate country of child's origin: ______________________________________

Please indicate any extenuating circumstances we should be aware of:

PREGNANCY:

Length of pregnancy: ___________________ Mother's age at child's birth: _______

While pregnant, did the mother smoke? __ Yes __ No If yes, what amount? ____________

While pregnant, did the mother use drugs or alcohol? __ Yes __ No

If yes, please indicate type and amount of substance used:____

While pregnant, did the mother have any medical or emotional difficulties?

BIRTH

Induced: __ Yes __ No Caesarean: __ Yes __ No Baby's birth weight: _____ Baby's birth length:__________

Please describe any physical or emotional complications with the delivery (breathing problems, cord around neck, color, jaundice, other) : ____

Early Childhood (Birth to Three) Check all that apply:

Did your child meet all early developmental milestones in a timely manner?

	Yes	No	Unsure?
Rolling over (3-4 months)	___	___	___
Sitting up alone (5-7 months)	___	___	___
Babbling (5-7 months)	___	___	___
Crawling (8-10 months)	___	___	___
Walking (11-14 months)	___	___	___
First solid foods (9-12 months)	___	___	___
First words (1 year)	___	___	___
Combine words (2 years)	___	___	___

Other:_______________

As a toddler, was your child (circle those that apply):

Intense Interested in their surroundings Friendly with strangers Affectionate

Attached to an object Overactive Independent

Interested in people vs. objects Interested in objects vs. people A self-starter

Please check if there is a history of the following behaviors and indicate approximate age:

_____ Head Banging	_____ Stuttering	_____ Breath holding	_____ Day soiling
_____ Tantrums	_____ Jealousy	_____ Hitting	_____ Difficulty w/transitions
_____ Frequent crying	_____ Irritability	_____ Thumb sucking	_____ Masturbation
_____ Hurting self	_____ Sleep Problems	_____ Nightmares	_____ Bedwetting
_____ Excessive Fear	_____ Hurting Others	_____ Problems w/peers	_____ Poor eye contact
_____ Aggression	_____ Prefers to be alone		

Does your child seem to be overly sensitive to sensory experiences?

Auditory:____

Visual:____

Tactile:____

Movement:____

Taste:____

Smell:

Has your child ever been treated for sensory processing difficulties? Yes No
Description:

Please identify any specific concerns your pediatrician has had regarding your child's overall development:

EDUCATION

Current School: ____

Does the child have an active IEP? __ Yes __ No

If yes, please describe: ____

Are they in a gifted program? __ Yes __ No

If yes, please describe: ____

Has the child ever been held back in school? __ Yes __ No

If yes, please describe: ____

Has the child undergone a psychological evaluation? __ Yes __ No

If yes, please note where it was completed: ___________________________________

Does your child receive any additional services or programming at school? Yes No
Description:

MEDICAL HEALTH HISTORY

Has your child had any of the following? Please circle.

recurrent ear infections	allergies	sleep disturbances
adenoidectomy	tonsillectomy	PE tubes
thumb/finger sucking	concussion	head injury
seizures	vision problems	serious illness/injury
high fever	respiratory problems	food allergies/dietary issues

other: ________________

Has your child ever been diagnosed with: Please circle.

ADD	ADHD	Anxiety Disorder
Mood Disorder	Autism Spectrum Disorder	Cognitive Delay
Failure to Thrive	Pervasive Developmental Disorder	

Learning Disabilities: ____

Genetic Disorder: ____

Other: ____

Please list any current medications your child is taking:
Medication: ________________________ Purpose: _________________________
Medication: ________________________ Purpose: _________________________
Medication: ________________________ Purpose: _________________________

Please list dates of most recent hearing and/or vision testing and results:
Hearing:____
Vision:____

Please describe any history of vision or hearing problems:

Are there any medical precautions the therapist should be aware of when working with your child?

Is your child in good general health at the present time? Yes No

Is there any additional information you think we should know about your child?

***Please attach prior assessments, IEP's, academic records etc.**

Name of person completing form: __________________________ Date: ______________