Leslie Gavin, Ph.D.
Licensed Psychologist

Developmental Questionnaire

Please complete this questionnaire prior to your visit.

Today's Date: _____

Identifying Information

Patient's Name	**Age**	**Date of Birth**	**Gender**	**Ethnicity**

Address

Contact Information:

Name	Cell phone	Landline	email

Family Information:

	Name	Age	Gender	Ethnicity	Job	Bio/half/step?
Household #1						
Parent 1						
Parent 2						
Household #2						
Parent 1						
Parent 2						
Sibling						
Sibling						
Sibling						

Is this child adopted?	Yes	No	
Does the child know he/she was adopted?	Yes	No	
Is/was this child in foster care?	Yes	No	
Has the Dept. of Children and Families ever been involved with your family?	Yes	No	

Primary Concerns

Who referred you to Dr. Gavin?	
What is your primary concern?	
What is your goal for meeting with Dr. Gavin?	

Birth History

How much did this child weigh at birth? _____ Pounds _____ounces
Length of pregnancy: _____weeks

Did the mother use any substances of medications during the pregnancy?

Beer/Wine /Alcohol	Yes	No	
Tobacco	Yes	No	
Marijuana	Yes	No	
Methamphetamine	Yes	No	
Opioid	Yes	No	
Other illegal drugs	Yes	No	
Prescribed medications?	Yes	No	

Problems during pregnancy?	Yes	No	
Birth trauma?	Yes	No	
Neonatal ICU stay?	Yes	No	
Was the baby ever without oxygen?	Yes	No	
Early hospitalizations?	Yes	No	
Early Intervention before age 3 for speech, OT or PT?	Yes	No	

Developmental Milestones

Was your child:			Explain delays
Sitting up by 8 months?	Yes	No	
Walking by 15 months?	Yes	No	
Saying words by one year?	Yes	No	
Using 2-word phrases by 2 years?	Yes	No	
Is your child toilet trained?	Yes	No	

Health History Has the child experienced any of the following? Place a check mark if yes.

Frequent ear infections?		Head injury or loss of consciousness?		Sleep problems?	
Seizures?		Heart problems?		Eating issues?	
Vision /hearing problems?		Abdominal pain?		Sensory sensitivities?	
Difficulties with growth?		Headaches?		Toileting issues?	
Hospitalization or surgery?		Lead exposure?		Breathing problems?	

School History

Name of School	Dates of attendance?	Any special services?

Has your child:

			If yes, please explain
Repeated a grade	Yes	No	
Had psychoeducational testing	Yes	No	
Received a 504 Plan or IEP	Yes	No	
Received detention/suspension/expulsion	Yes	No	
Been home-schooled	Yes	No	

Child Mental Health History

Has this child ever received a mental health diagnosis?

Diagnosis	Date of diagnosis	Who diagnosed?

Has this child ever taken medications for behavioral/emotional concerns? Specify:

Current Medications	Medication for?	Dosage

Has your child been in:

	No	Yes? Please explain
Psychological counseling?		
ABA behavior therapy?		
Occupational Therapy?		
Speech therapy?		
Psychiatric hospitalization?		

Family Mental Health History

Does this child have relatives with any of the following?

Depression? If yes, please explain.	Learning disabilities? If yes, please explain.
Bipolar Disorder/Manic Depression? If yes, please explain.	Autism Spectrum Disorder? If yes, please explain.
Schizophrenia? If yes, please explain.	Alcohol/drug problems? If yes, please explain.
Eating disorder? If yes, please explain.	Tics or Tourette syndrome? If yes, please explain.
Developmental or Intellectual Disability? If yes, please explain.	Seizures? If yes, please explain.
Language delay/impairment? If yes, please explain.	Other neurological problems? If yes, please explain.