DEVELOPMENTAL QUESTIONNAIRE

Darrell R. Johnson, Ph.D.

File number: _____

Date: ____/____/____
(Day) (Month) (Year)

Name of parent: _____

Name of child: _____

Child's date of birth: ____/____/____
(Day) (Month) (Year)

INFANCY/ EARLY CHILDHOOD

(Please circle appropriate choices):

If adopted, at what age? _____ Age when told of adoption? _____

Any difficulties during pregnancy, delivery, or shortly thereafter? Yes/ No/ Unknown

Please describe: _____

Birth weight: _____ Breast fed? Yes/ No/ Unknown Colic? Yes/ No/ Unknown

Temperament: quiet/ easy/ slow to warm up/ fussy/ cries a lot/ sick a lot/ other _____

Developmental Milestones (√):

	Age (if known)		Early		Average		Late		Unknown	
Slept through the night										
Sat										
Walked										
Spoke first words										
Bladder trained (day/ night)										
Bowel trained (day/ night)										

Any unusual behaviours as an infant? Yes/ No/ Unknown
Please describe: _____

Any serious illnesses or hospitalizations as an infant? Yes/ No
Please describe: _____

Any other difficulties? _____

Age when first separated from mother
For a few hours _____
Overnight _____
For several nights _____

Any long separations from parents? Yes/ No
Please describe: _____

Any difficulties when away from parents? Yes/ No
Please describe: _____

SCHOOL YEARS/ ADOLESCENCE

Problems when first attending school? Yes/ No
Please describe: _____

Psychological Assessment? Yes/ No Date: ____/____/____ (Day) (Month) (Year)

Please describe findings: _____
_____

Diagnosed learning difficulties? Yes/ No
Please describe: _____

Discipline problems in school? Yes/ No
Please describe: _____

Ever saw a counselor/ social worker? Yes/ No Date: ____/____/____ (Day) (Month) (Year)

Difficulties with peers? Yes/ No
Please describe: _____

Best school subject/ special talents or abilities/ favourite sports or activities:

_____
_____
_____
_____
_____

PHYSICAL HEALTH (Family)

(Please circle any known physical conditions—indicate "p" for parent, "c" for child):

Diabetes	_____	Epilepsy	_____	Cancer	_____	Seizures	_____
Heart Disease	_____	Inherited diseases	_____	Drug Abuse	_____	Eczema	_____
Drinking Problems	_____	Severe headaches	_____	Ulcers	_____	Allergies	_____
High blood pressure	_____	Hearing problems	_____	Vision problems	_____		
Weight problems	_____	Frequent accidents	_____	Sleep problems	_____		

EMOTIONAL HEALTH (Family)

Any previous contact with mental health professionals? Yes/ No
Please describe: _____

Outcome of previous therapies: Positive Negative Mixed
Please describe: _____
_____
_____
_____

YOUR INITIAL TREATMENT GOALS

Your reason(s) for consulting:

_____
_____
_____
_____
_____
_____

Your initial goals or expectations (if any are clear to you at this time):

_____
_____
_____
_____
_____
_____

Type of therapy you desire:

☐ Individual ☐ Couple ☐ Family ☐ Child or Adolescent ☐ Parent Coaching ☐ Not yet determined

Any questions you might have for me at this point:

_____
_____
_____
_____
_____
_____
_____

_____
(Your signature)

www.DrJohnson.ca tel. : (514) 213 – 5502 dj@drjohnson.ca