Mary Determan MSW, LLC

5757 W. Oklahoma Ave. #203 Milwaukee, WI 53219-4303

Developmental and Social History Questionnaire

Child's Name	
Date of Birth	
Current Grade	
Name of Person Completing Form	
Current Date	

Presenting Concerns:			
Chief Complaint {These would be the current areas of concern}. Please check any that are appropriate:			
Behavior	☐ temper tantrums ☐ disobedience ☐ social skills ☐ hyperactive ☐ defiant ☐ interrupts adults	☐ physical aggression ☐ stealing ☐ eating disorder ☐ verbal aggression ☐ accident prone ☐ clumsiness	☐ memory ☐ fighting ☐ impulsive ☐ Inattentive ☐ attention span ☐ awareness of danger/safety
Emotional	☐ anger management ☐ appetite changes ☐ self-esteem	☐ anxiety ☐ easily frustrated ☐ sleep	☐ quick mood changes ☐ fears ☐ attachment
Academic	☐ reading difficulties ☐ writing difficulties ☐ suspensions/expulsions	☐ spelling difficulties ☐ speech difficulties ☐ overall poor education	☐ math difficulties ☐ reading comprehension
Reasoning	☐ poor problem solving	☐ poor assessment of risk	
Readiness	☐ Understands there is a problem and wants help ☐ Understands there is a problem and not overly interested in help ☐ Understands there is a problem and doesn't want help ☐ Doesn't understand that there is a problem		

Previous Mental Health/Behavioral Evaluations: Please check any that have occurred:	
Name of Psychiatrist:	**When:**
	Diagnosis:
Name of Past Therapist:	**When:**
	Diagnosis:
Name of School Psychologist/School Social Worker:	**When:**
	Diagnosis:
Name of OT/PT:	**When:**
	Diagnosis:
Other Service Provider:	**When:**
	Diagnosis:

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FAMILY BACKGROUND INFORMATION	
Primary language of home/parents?	
Primary language of child?	
Are child's biological parents now together?	☐ Yes ☐ No
If no, separated or divorced when?	
What are the custody and visiting arrangements?	
Are there currently any custody disputes about the child?	☐ Yes ☐ No
If separated or divorced, how do you feel your child has adjusted to the separation/divorce?	
Is your child adopted?	☐ Yes ☐ No
If yes, how old was your child at the time of adoption?	
Is your child aware of the adoption?	☐ Yes ☐ No
Does cultural heritage play a significant role in your daily life?	☐ Yes ☐ No
Has your child experienced any of the following? If yes, explain.	
Physical abuse?	☐ Yes ☐ No
Sexual molestation, sexual abuse?	☐ Yes ☐ No
Emotional abuse or neglect?	☐ Yes ☐ No
Medical trauma?	☐ Yes ☐ No
Death of parent, sibling, or close relative?	☐ Yes ☐ No
Removal from the home due to abandonment or neglect?	☐ Yes ☐ No
Alcohol or drug abuse by a parent or sibling?	☐ Yes ☐ No
Witnessed violence or abuse by a parent or sibling?	☐ Yes ☐ No
Criminal arrest and/or court proceedings (e.g., juvenile arrest, custody dispute)?	☐ Yes ☐ No
Serious illness or disability; either the child him/herself or in a close relative?	☐ Yes ☐ No
Separation from one or both parents for an extended period of time?	☐ Yes ☐ No
Other situations that may have been traumatic:	

List all persons currently living in the child's household:			
Name	Age	Relationship to child	How well does your child get along with him/her?

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Family History (has anyone in your family ever been treated for any of the following)?							
	Father	Mother	Aunt	Uncle	Brother	Sister	Grandparent
Depression	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Anxiety	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Panic Attacks	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Post Traumatic Stress	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Bipolar Disorder/ Manic Depression	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Schizophrenia	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Alcohol Problems	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Drug Problems	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
ADHD	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Suicide Attempts	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**
Psychiatric Hospitalization	☐	☐	☐ **Maternal** ☐ **Paternal**	☐ **Maternal** ☐ **Paternal**	☐	☐	☐ **Maternal** ☐ **Paternal**

EDUCATION			
List all schools the child has attended:			
	School Name	**Location**	**Start/End Dates**
Preschool			
Kindergarten			
Grades 1-3			
Middle School 4-6			
Junior High 7-8			
High School 9-12			

Which of the following best describe your child's school behavior and attitude: (Check all that apply)			
☐ happy	☐ sad	☐ well-adjusted	☐ doesn't want to attend
☐ fearful	☐ hurts other kids	☐ distracted easily	☐ argues with the teacher
☐ withdrawn	☐ disruptive	☐ refuses to work	☐ doesn't make friends
☐ poor attention	☐ has difficulty learning	☐ does not remain seated	☐ other
Does your child/youth have a job?		☐ Yes ☐ No	
Has your child/youth experienced school violence?		☐ Yes ☐ No	

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BIRTH AND EARLY CHILDHOOD INFORMATION	
Pregnancy and Birth ☐ **N/A Adopted**	
Describe any complications, medications, or other concerns the mother experienced before or during the pregnancy: (e.g., diabetes, high blood pressure, toxemia, etc.)	
During pregnancy, mother's strong emotional stresses, if any:	
What was duration of pregnancy:	
Birth Weight	
Please describe any complications the child experienced with the birth, delivery, or after delivery: (e.g., low Apgar scores, cord around neck, breathing difficulties, time in the NICU, etc.)	

Adoption Information ☐ **N/A**	
Was the adoption open or closed?	
What was the age of the child at adoption?	
Was the child from outside of the United States?	
What information is known about the birth mother?	
What information is known about the birth father?	
What information is known about environments and Extended families of the birth parents?	
How did the child do with attachment to adoptive Parents, siblings, and other family members and friends?	

Open Adoption ☐ **N/A**	
How was the relationship with the birth parent(s) prior To having the baby join your family?	
How much time did the baby spend with the birth parent(s)? How was the quality of this time?	
Did anyone else take care of the baby?	
What is the present agreement for communication With the birth family?	

Artificial Insemination Information ☐ **N/A**

Foster Care Information ☐ **N/A**	
Date child joined your family:	
What were the circumstances of the child's life just prior to coming to your home?	
How was the transition?	
What strengths do you see in the child?	
What information is known about the child's history in the birth family?	
What were the circumstances of the child's leaving the birth family?	

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Developmental Milestones								
Milestone	0-3 Months	4-6 Months	7-12 Months	13-18 Months	19-24 Months	2-3 Years	3-4 Years	Other Specify age
Sat up without help	☐	☐	☐	☐	☐	☐	☐	☐
Crawled	☐	☐	☐	☐	☐	☐	☐	☐
Walked alone	☐	☐	☐	☐	☐	☐	☐	☐
Walked up stairs	☐	☐	☐	☐	☐	☐	☐	☐
Spoke first words	☐	☐	☐	☐	☐	☐	☐	☐
Spoke short phrases	☐	☐	☐	☐	☐	☐	☐	☐
Spoke in Sentences	☐	☐	☐	☐	☐	☐	☐	☐
Fully bladder trained	☐	☐	☐	☐	☐	☐	☐	☐
Fully bowel trained	☐	☐	☐	☐	☐	☐	☐	☐
Stays dry all night	☐	☐	☐	☐	☐	☐	☐	☐

HEALTH
Child/Adolescent Sleep Checklist
What time does your child/adolescent go to bed? On school nights: ___:___ ☐**PM** ☐**AM** On weekends: ___:___ ☐**PM** ☐**AM**
How long does it take your child/adolescent to fall asleep? ☐ 20 minutes or less ☐ 40 minutes or less ☐ 1 hour or less ☐ more than 1 hour
How many times does your child/adolescent wake up in the middle of the night? _____ times on average
What time does your child/adolescent get out of bed? On school days: ___:___ ☐**PM** ☐**AM** On weekends: ___:___ ☐**PM** ☐**AM**
How long does your child usually sleep at night? On school days (weeknights): ___ hours and ___ minutes On weekends: ___ hours and ___ minutes
At night my child: ☐ gets enough sleep ☐ gets almost enough sleep ☐ doesn't really get enough sleep
In the morning: ☐ my child/adolescent wakes up by him/herself ☐ my child/adolescent wakes up with an alarm ☐ someone wakes my child/adolescent
How long does it take your child/adolescent to get out of bed after his/her alarm goes off or someone wakes him/her up ☐ 20 minutes or less ☐ 40 minutes or less ☐ 1 hour or less ☐ more than 1 hour
My child/adolescent takes a nap in the afternoon or evening ___times per week. My child/adolescent starts his/her nap at ___:___PM and sleeps for ___ minutes.
My child/adolescent goes to afterschool clubs, sports practices ___times per week. At the latest, my child/adolescent gets home at _____PM.
Who sleeps in the same room with your child/adolescent at night? ☐ My child/adolescent sleeps alone ☐ Brothers and sisters ☐ Parents ☐ Grandparents
Has your child/adolescent ever been told that his/her tonsils or adenoids are big? ☐ Yes ☐ No

Has the child ever been hospitalized? ☐ **N/A**		
Reason for Hospitalization	Age of Child	Duration

Appetite						
	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
Your child/adolescent is a picky eater.						
Your child/adolescent dislikes most of the foods that other people eat.						
Your child/adolescent's list of foods that they like to eat is shorter that the list of foods they won't eat.						
Your child/adolescent is not interested in eating; they seem to have a smaller appetite than other people.						
Your child/adolescent has to push themselves to eat regular meals throughout the day, or to eat a large enough amount of food at meals.						
Even when your child/adolescent is eating a food they like, it is hard for them to eat a large enough volume at meals.						
Your child/adolescent puts off eating because they are afraid of GI discomfort, choking, or vomiting.						

Wetting at Night ☐ **N/A**	
How many nights a week does your child stay dry?	
How many days in a row has your child been able to stay dry?	
Please check any and all of the following ways you have used to help your child stay dry all night. ☐ Diaper or "Pull-up" ☐ Drinking little or less after dinner ☐ Alarm Clock wakes at night ☐ Acupuncture/Acupressure ☐ Trying to remember to keep dry ☐ Enuresis Alarm	 ☐ Hypnosis ☐ Keeping "Dry Night" calendar ☐ Parent wakes at night ☐ Punishment for wet nights ☐ Rewards for dry nights
Have you ever used any of these medicines to treat enuresis? ☐ Imipramine (Tofranil) ☐ Desmopressin (DDAVP) ☐ Oxybutinin (Ditropan)	 ☐ Homeopathic medicine ☐ Herbal Substance ☐ Other
When your child needs to urinate during the day, do you have to go right away?	☐ Yes ☐ No
Does your child sometimes urinate in their clothes by accident during the day?	☐ Yes ☐ No
Does your child sometimes have a bowel movement in their clothes by accident during the day?	☐ Yes ☐ No
Is it hard for your child to have a bowel movement most days?	☐ Yes ☐ No
Does your child take any medicine to help them have bowel movements most days?	☐ Yes ☐ No

Gender		
Has your child repeatedly stated a desire to be, or an instance that he or she is, a member of the opposite sex?	☐ **Yes**	☐ **No**
Does your son get upset, sad or angry when he is treated like a boy, or does your daughter get upset, sad or angry when she is treated like a girl? This can mean when wearing clothes associated with their birth sex, being called by their name, being told they are a boy/girl, etc?	☐ **Yes**	☐ **No**
When your child plays make-believe games, does he or she show a strong preference for playing cross-gender roles? And/or do they often fantasize about being born the other gender?	☐ **Yes**	☐ **No**
Does your child enjoy playing with toys, games or activities stereotypical of the other gender?	☐ **Yes**	☐ **No**
Does your child often express a strong dislike for, or avoidance of, his or her sexual anatomy?	☐ **Yes**	☐ **No**
Does your child tell you that he or she wishes he/she had the primary (e.g. penis or vagina) or secondary (e.g. facial hair or breasts) sex characteristics of the opposite sex?	☐ **Yes**	☐ **No**
Is your child experiencing significant distress or impairment in social, school, or other important areas of functioning?	☐ **Yes**	☐ **No**
If your child is going through puberty did they react in a strongly negative way to the changes happening in their body? Examples for boys: beard and body hair growth. Examples for girls: breast growth or starting menstruation.	☐ **Yes**	☐ **No**

Social Interaction		
Do you currently have any concerns about your child/adolescent's social skills?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty empathizing with others, appreciating another person's perspective or point of view?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty handling transitions, shifting from one mindset or task to another?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty considering the likely outcomes or consequences of actions?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty persisting on challenging or tedious tasks?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty considering a range of solutions to a problem?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty expressing concerns, needs, or thoughts in words?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty managing emotional response to frustration?	☐ **Yes**	☐ **No**
Does your child/adolescent have chronic irritability and/or anxiety which significantly impedes their capacity for problem-solving or heightened frustration?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty seeing the "greys"/concrete, literal, black & white thinking?	☐ **Yes**	☐ **No**
Does your child/adolescent have inflexible, inaccurate interpretations/cognitive distortions or biases (i.e., "Everyone's out to get me," "Nobody likes me.")?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty attending to or accurately interpreting social cues/poor perception of social nuances?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty appreciating how his/her behavior is affecting others?	☐ **Yes**	☐ **No**
Does your child/adolescent have difficulty starting conversations, entering groups, connecting with people/lacking other basic social skills?	☐ **Yes**	☐ **No**