Child Development Questionnaire (CDQ)

Stefan C. Dombrowski, Ph.D.

Demographic Information

Child's Name: _____

Date: _____

Sex:

☐ Male

☐ Female

☐ Transgender

Grade: _____

Date of Birth: _____

Race/Ethnicity: (Please select all at that apply)

☐ White

☐ Black or African-American

☐ Native Hawaiian or Pacific Islander

☐ Asian

☐ Hispanic or Latino

☐ Native American or Native Alaskan

☐ Other: _____

Primary Language(s) spoken in home:

_____

Preferred language? _____

English a Second Language:

☐ Yes or

☐ No?

Describe: _____

Name of Person Completing Form: ____

_____

Relationship to Child:

☐ Biological parent

☐ Stepparent

☐ Grandparent

☐ Foster Parent

☐ Aunt/Uncle Other _____

Address: _____

Mobile Phone: _____

Home Phone: _____

Work Phone: _____

Reason for Evaluation: _____

_____

At what age did you first become concerned? _____

What are your concerns about your child? (Check all that apply)

☐ Language/Speech/Communication

☐ Cognitive/learning development

☐ Emotional development

☐ Medical

☐ Motor development

☐ Behavior problems

☐ School performance

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Parental Information

Mother's Name: _____
Age: _____

Highest Grade Level Completed:

- ☐ 9th grade
- ☐ High School
- ☐ Some College
- ☐ Associates Degree
- ☐ Bachelor's
- ☐ Master's or Juris Doctor
- ☐ Doctorate (M.D., Ph.D., DDS, DVM)

Schools Attended: _____

Occupation _____

Primary Language: _____

Secondary Language: _____

Father's Name: _____
Age: _____

Highest Grade Level Completed:

- ☐ 9th grade
- ☐ High School
- ☐ Some College
- ☐ Associates Degree
- ☐ Bachelor's
- ☐ Master's or Juris Doctor
- ☐ Doctorate (M.D., Ph.D., DDS, DVM)

Schools Attended: _____

Occupation _____

Primary Language: _____

Secondary Language: _____

Family Constellation

Where and with whom does the child reside? _____

Are parents

- ☐ Together
- ☐ Separated

Individuals living with child:

Name	Age	Sex	Relationship to Child

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Child Strengths, Interests and Hobbies

What are the child's strengths? _____

What are the child's interests and hobbies? _____

With what activities is the child involved? _____

Prenatal History

Number of prior pregnancies _____

Was Mom under doctor's care during pregnancy? _____ If so, how many visits? _____

Was the pregnancy _____

☐ Planned

☐ Planned with preconception counseling

☐ Unplanned

Experience of any of the following during pregnancy:

☐ Difficulty getting pregnant with this child?

Fertility treatment? Yes or No Describe:

Multiple Fetuses during pregnancy? Yes or No Describe:

Infection(s) during Pregnancy: (Please select all that apply)

☐ Influenza

☐ Fever

☐ Measles

☐ Chicken Pox

☐ Herpes

☐ HIV

☐ Other Sexually Transmitted Infections

☐ Other Infection

Need for bedrest?

☐ Yes

☐ No

How long? _____

Hospitalization during pregnancy:

☐ Yes

☐ No

Why? _____

Maternal injury during pregnancy?

☐ Yes

☐ No

Premature rupture of membranes?

☐ Yes

Substance Use during Pregnancy

☐ Alcohol: Frequency: _____

☐ Cocaine: Frequency: _____

☐ Marijuana: Frequency: _____

☐ Heroin: Frequency: _____

☐ Other: Frequency: _____

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Cigarettes Used During Pregnancy?

☐ Yes

☐ No

Frequency: _____

Prescription Medication (s) taken during pregnancy?

☐ Yes

☐ No

Describe: _____

During pregnancy, mother had

☐ High blood pressure

☐ Diabetes

☐ Sexually Transmitted Infection

☐ Measles

Abnormal Ultrasound:

☐ Yes

☐ No

Explain: _____

Abnormal tests during pregnancy:

☐ Yes

☐ No

Explain: _____

Stress during Pregnancy:

☐ Yes

☐ No

Explain: _____

Other pregnancy problems:

☐ Yes

☐ No

Explain: _____

Perinatal

Age of Mother at birth of child: _____

Age of Father at Birth of the child: _____

Length of Pregnancy: _____ Weeks: ____

Birthweight ____lbs ____ oz

Length at birth: ____ inches

Labor Length: _____ Hours

Delivery Type:

☐ Vaginal

☐ C-section

☐ Breech

Delivery Type (Continued)

☐ Forceps

☐ Vacuum used

Antibiotics given during labor?

☐ Yes

☐ No

Any placental issues?

☐ Yes

☐ No

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Did the baby experience any of the following:

- ☐ Jaundice
- ☐ Apnea
- ☐ Bilirubin Lights
- ☐ Reflux
- ☐ NICU stay
- ☐ Blood problems
- ☐ Breathing Problems
- ☐ Tube feeding
- ☐ Need for ventilator
- ☐ Low oxygen
- ☐ Infection
- ☐ Feeding/Sucking problems
- ☐ Intraventricular hemorrhage (bleeding in the brain):

Medication (s) given to baby:

Early Developmental History

Breastfed

- ☐ Yes
- ☐ No

Until What age? _____

Overall baby was

- ☐ Easy
- ☐ Moderate
- ☐ Difficult

Early Developmental Milestones

(Check and include comments, if appropriate)

Gross Motor	Normal	Abnormal
Turn over	☐	☐
Sit alone	☐	☐
Crawl	☐	☐
Pull to stand	☐	☐
Walk alone	☐	☐
Climb up stairs	☐	☐
Walk	☐	☐
Run	☐	☐
Hop	☐	☐
Pedal tricycle	☐	☐
Ride Two wheel bike	☐	☐
Throwing	☐	☐
Catching	☐	☐

Fine Motor	Normal	Abnormal
Reach for Objects	☐	☐
Zippers & buttons	☐	☐
Pincer grasp	☐	☐
Uses spoon	☐	☐
Removes clothing	☐	☐
Feeds with fingers	☐	☐
Hold cup	☐	☐
Prints name	☐	☐
Draws picture	☐	☐
Tie Shoes	☐	☐

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Language/Social	Normal	Abnormal
Smiles at others	☐	☐
Coo	☐	☐
Laugh	☐	☐
Babble	☐	☐
Wave bye-bye	☐	☐
Say mama/dada	☐	☐
Says first word	☐	☐
Point to object	☐	☐
Follow command with gesture	☐	☐
States name	☐	☐
Uses complete sentences	☐	☐
Holds conversation	☐	☐

Language/Social	Normal	Abnormal
Loss of language	☐	☐
Share emotion	☐	☐

Toilet trained

☐ Yes

☐ No

Age: _____

☐ Urine: _____ Daytime _____ At night:

☐ Stool: _____ Daytime _____ At night:

☐ Problems toileting?

Explain: _____

Behavioral and Temperamental History

Temperament

Activity Level:	☐ Normal	☐ High	☐ Low
Mood:	☐ Normal	☐ Happy	☐ Sad
Task Persistence	☐ High	☐ Medium	☐ Low
Irritability	☐ Low	☐ Average	☐ High
Fearfulness	☐ Low	☐ Average	☐ High
Shyness	☐ Low	☐ Average	☐ High
Adaptable/Flexible	☐ Low	☐ Average	☐ High

Sociability and Play

Does or did your child (check all that apply):

☐ Ignore children ☐ Initiate play ☐ Observe them ☐ Parallel play

☐ Join play ☐ Intrude on play ☐ Prefer adults ☐ Play alone

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Sports/Hobbies/Interests

Describe your child's hobbies, sports and interests?

_____

Has there been a decrease in interest in participating in these activities recently?

_____

Behavior

Does your child have difficulty with any of the following (currently or past)

☐ Colic	☐ Obsessions/Compulsions	☐ Sleeping (too little or too much)
☐ Eating	☐ Unusual Interests	☐ Temper Tantrums
☐ Head banging	☐ Unusual body movements	☐ Hitting others
☐ Biting	☐ Forgetfulness	☐ Distractibility
☐ Attention span	☐ Concentration	☐ Hyperactivity
☐ Task completion	☐ Trouble with Peers	☐ Fears
☐ Stealing	☐ Destructiveness	☐ Fighting
☐ Anxiety	☐ Need for same routine	☐ Involvement with law
☐ Irritability	☐ Rituals	☐ Trouble with siblings
☐ Impulsivity	☐ Fire setting	☐ Self-stimulation
☐ Excessive crying	☐ Failure to thrive	☐ Separating from parents
☐ Sensory issues	☐ Overreactivity to problems	☐ Meeting new people
☐ Calming down	☐ Unhappiness	☐ Needs parental supervision
☐ Smoke	☐ Drink alcohol	☐ Use illicit substances

Comments:_____

Parenting Style

How do you deal with behavioral issues? (Check all that apply)

☐ Ignoring	☐ Explaining	☐ Scolding
☐ Spanking	☐ Send child to room/Time out	☐ Removal of privileges
☐ Reinforcement	☐ Other: _____	

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Educational History

Attend daycare/preschool? ☐ Yes ☐ No At what age? _____

Attend Kindergarten? ☐ Yes ☐ No At what age? _____

Any problems in daycare/preschool or kindergarten? ☐ Yes ☐ No

Explain: _____

_____

_____

Does your child or did your child receive any of the following services:	**When**	**Frequency**	**Service Provider**
Early intervention			
Feeding therapy			
Physical therapy			
Occupational therapy			
Speech therapy			
Behavior therapy			
Other			

Elementary/Middle School/High School

	Check if applicable	Explain
Ever change schools?		
Repeated a grade?		
Skipped a grade?		
Difficulty with Reading?		
Difficulty with Math?		
Difficulty with writing?		
Receives poor grades?		
Been tested for special education?		
Frequent absences?		

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Medical History

	Normal	Abnormal	Comments
Head, eyes, ears, nose, throat			
Vision Screening (Date: _____)			
Hearing Screening (Date: _____)			
Heart			
Lungs			
Kidney			
Stomach/Intestinal/Constipation			
Reflux			
Asthma			
Feeding Issues			
Eczema/Skin issues			
Seizures			
Muscles			
Cerebral Palsy			
Joints/Bones			
Nervous system			
Exposure to toxins (lead; cigarette smoke; mold)			
Sleeping/Snoring			
Nutrition/Diet			
Other			

Celiac ☐ Yes ☐ No Allergies ☐ Yes ☐ No Explain: _____

Immunizations up to date ☐ Yes ☐ No Explain: _____

Diagnosed with any medical or genetic conditions? ☐ Yes ☐ No

Explain: _____

Is the child a picky eater?

Explain: _____

Hospitalizations

Date: _____ Reason _____

Date: _____ Reason _____

Date: _____ Reason _____

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Medications

Name _____ Dose _____

Frequency _____

Family History

Condition	Biological Father's Side	Biological Mother's Side	Sibling
ADHD			
Learning Disabilities			
Speech Problems			
Autism Spectrum Disorder			
Cognitive Delays			
Suicide			
Bipolar Disorder			
Anxiety			
Depression			
Birth Defects			
Genetic Disorders			
Seizures			
Substance Abuse			
Obsessive Compulsive Disorder			
Tics/Tourette's			
Thyroid Disorders			
Behavior Problems			
Contact with law			
Medications for Mental Health			
Other			

Additional Remarks/Comments:
