Tiffany Griffiths, Psy.D. & Associates, Inc.

502 N. Blakely St.
Dunmore, PA 18512
(570) 342-8434

406 N. State St.
Clarks Summit, PA 18411
(570) 342-8434

1251 Wyoming Ave.
Exeter, PA 18643
(570) 654-4357

1031 Main St.
Peckville, PA 18452
(570) 342-8434

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's full name: _____ Date of Birth _____ Age_____

Grade_____ Classroom teacher:_____

Current Address: _____

How long at this address? _____

Person providing information: _____

Relationship to child_____

Who does child live with: □ both parents □ mother □ father □ other (specify) _____

Biological father_____ Occupation_____ Years education: _____

Father's home phone_____ Work #_____ Cell #_____

Biological mother_____ Occupation_____ Years education: _____

Mother's home phone _____ Work #_____ Cell #_____

If applicable: Guardian's name_____ Occupation _____Years education

Guardian's home phone _____ Work #_____Cell # _____

Please list all people in child's immediate family:_____

_____

_____

_____

Name Relationship to child/ Age / Grade /Living in house?_____

_____

_____

Please list all other *non-family* members who live in household:_____

_____

Language(s) spoken at home _____

Primary Language at home_____

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace _____ Moved at age_____grade_____

_____

2. _____ Moved at age_____grade_____

_____

3. _____ Moved at age_____grade_____

_____

4. _____ Moved at age_____grade_____

_____

Are biological parents of child currently: □ married □ separated □divorced □ never married?

• If separated or divorced, who has *legal* custody? □ Mother □ father □ other (specify): _____

_____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce?_____

_____

Are there other adults who have a ***significant*** part in raising your child? □Yes □No

If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.)_____

_____

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc)_____

_____

_____

_____

What do you feel are your child's…

Strengths_____

Weaknesses _____

Briefly describe your concerns for your child._____

_____

_____

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is your child: □ biological child □ adopted child □ foster child □ other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used: _____

_____

Pregnancy lasted _____weeks / months Child's birth weight: _____pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No

If No, explain why:_____

_____

Please check the conditions below that describe the health of the child and mother during…

Mothers pregnancy	Child's Delivery	Child's Condition at Birth
☐ No complications	☐ Normal	☐ Normal
☐ Blackouts	☐ Induced labor	☐ Lack of oxygen
☐ Falls	☐ C-section	☐ Breathing problem
☐ Physical injury	☐ Breech birth	☐ Birth injury/defect
☐ Excessive bleeding	☐ Unusually long labor (>12 hours)	☐ Jaundice
☐ Hypertension	☐ Premature # of weeks	☐ Newborn ICU # of days
☐ Diabetes	☐ Overdue # of weeks	☐ Other problem (specify)
☐ Emotional stress	☐ Other problem (specify)	
☐ Toxemia		
☐ Alcohol and/or drug use		
☐ Use of tobacco		

B. Health

Describe the state of your child's current health: □ Excellent □ Good □ Fair □ Poor

Is your child currently taking any medication? □Yes □ No

If yes, please list medications and uses: _____

_____

_____

_____

_____

Has your child ever been identified as having a disability? □Yes □ No

If so, by whom, what age, & what disability? _____

_____

_____

_____

Has your child ever received psychological counseling? □Yes □ No

If so, by whom (professional/agency) and when: _____

_____

_____

_____

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc)? □Yes □ No

If so, by whom (professional/agency) and when: _____

_____

_____

_____

Has your child ever participated in educational services from a private entity (i.e., private tutor, Sylvan Learning Center)? □Yes □ No

If so, by whom (professional/agency) and when: _____

_____

Has your child ever participated in an early intervention program? □Yes □ No

If so, by whom (professional/agency) and when: _____

Has your child had any of the following? Please check all that apply.	Please describe and give details, dates, and/or age of onset
□ Serious Illnesses	
□ Head Injuries	
□ Seizures or convulsions	
□ Surgery/Hospitalization	
□ History of Ear Infections	
□ Allergies and/or Asthma	
□ Vision Problems	
□ Hearing Problems	
□ Frequent Nightmares and/or Bedwetting	
□ Other health problem	

Family History

Is there a ***family history*** for the following problems?	*Biological* family member with the history… (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
□ Learning Difficulties (reading, math, writing, spelling)	
□ Speech or Language problem (articulation, stuttering, etc.)	
□ Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
□ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
□ Intellectual Disability	
□ School Failure (failing grades, dropout, etc)	
□ Drug or Alcohol Addiction	

C. Development

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

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								
Stayed dry all night								

III. BEHAVIOR

A. Behavior in Infancy

During your child's first *few years of life*, were any of the following present to *significant* degree?

- ☐ Did not enjoy cuddling
- ☐ Was not easily calmed by being held or being stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Frequent head banging
- ☐ Difficult nursing
- ☐ Poor eye contact
- ☐ Did not turn towards caregivers
- ☐ Did not respond to name
- ☐ Did not respond to speech of caregivers
- ☐ Fascination with certain objects
- ☐ Constantly into everything

* Please describe all checked items_____

_____

_____

_____

B. Child's Early Temperament: (*Toddler through five years of age*)

Activity Level – How active has your child been from an early age?_____

Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks? _____

Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way? _____

Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)? _____

Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? _____

Mood **–** What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament? _____

Regularity **–** How predictable was your child's patterns of activity level, sleep, appetite, etc.? _____

Prior to age six, did your child have more difficulty than other children his/her age…

- ☐ Sitting still at meal time
- ☐ Paying attention when read to
- ☐ Throwing a ball
- ☐ Catching a ball
- ☐ Buttoning and zipping
- ☐ Holding a crayon or pencil
- ☐ Accidentally dropping things
- ☐ Staying focused on TV, movies, or video games
- ☐ Waiting for a turn to play
- ☐ Knowing left and right
- ☐ Acting without thinking
- ☐ Dressing self
- ☐ Tying shoe laces
- ☐ Accidentally knocking things over

C. Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- ☐ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- ☐ Talks excessively, interrupts often, doesn't listen
- ☐ Low energy/fatigue
- ☐ Poor concentration
- ☐ Difficulty initiating tasks
- ☐ Difficulty completing tasks
- ☐ Difficulty following instructions
- ☐ Often depressed/irritable mood
- ☐ Often loses things, very disorganized compared to others his/her age.
- ☐ Shy
- ☐ Feeling of worthlessness or low self-esteem
- ☐ Withdrawn
- ☐ Overly anxious or fearful
- ☐ Sleeping too little/insomnia

- ☐ Engages in impulsive behaviors (acts before thinking)
- ☐ Immature compared to peers
- ☐ Engages in physically dangerous activities
- ☐ Often argumentative with adults
- ☐ Often actively defiant to adult requests and rules
- ☐ Blames others for own mistakes
- ☐ Often angry or resentful
- ☐ Somatic complaints of not feeling well
- ☐ Excessive separation difficulties
- ☐ Easily frustrated
- ☐ Lies
- ☐ Steals
- ☐ Aggressive towards others
  - o Adults
  - o Peers
- ☐ Sleeping to much
- ☐ Difficulty making decisions
- ☐ Cries easily
- ☐ Temper tantrums
- ☐ Rapid mood changes/mood swings
- ☐ Suicidal thoughts
- ☐ Excessive need for reassurance
- ☐ Poor appetite
- ☐ Overeats
- ☐ Explosive temper with minimal provocation
- ☐ Odd fascinations
- ☐ Unrealistic worry about futures events
- ☐ Substance abuse
  - o Drug
  - o Alcohol
  - o other

Please explain all checked items: _____

_____

_____

_____

D. Home Behavior:

How often is each of the following settings a *problem* for your child?

While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
When eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
When playing by him/herself	☐ Rarely	☐ Sometimes	☐ Frequently
When playing with siblings/other children	☐ Rarely	☐ Sometimes	☐ Frequently
When with a babysitter or daycare	☐ Rarely	☐ Sometimes	☐ Frequently
In public places (church, store)	☐ Rarely	☐ Sometimes	☐ Frequently
When in the car	☐ Rarely	☐ Sometimes	☐ Frequently
When told to do something he/she doesn't want to do	☐ Rarely	☐ Sometimes	☐ Frequently
During sit-down homework time	☐ Rarely	☐ Sometimes	☐ Frequently
When watching TV or playing video games	☐ Rarely	☐ Sometimes	☐ Frequently

How would you describe your child's personality at home?_____

_____

How does your child get along with brothers/sisters? _____

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? (Spanking, talking, positive reinforcement, time-out, grounding, etc.)_____

How does your child respond to discipline?_____

List any responsibilities your child has at home: _____

Does your child do these regularly? __Yes __ No

Does your child need frequent reminders? __Yes __No

Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM Does child sleep well? __Yes __ No

How much time does your child typically spend on electronic media? _____

Watching T V: _____hrs/day; Playing video/computer games: _____hrs/day; Other:_____ hrs/day

Have any family members expressed concerns about your child's behavior? __Yes __ No

Explain:_____

E. Social Behavior:

How would you describe your child's peer relationships and choice of friends? (i.e. how many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?) _____

How does your child interact with children in the neighborhood? _____

IV. Educational History

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? □ not a struggle □ sometimes a struggle □ often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? □ Yes □ No

If yes, what services, when did they begin?_____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare_____

Elementary School_____

Middle School_____

High School _____