Child's Name: ___________________________

Developmental History Questionnaire

Caregivers: This questionnaire has been prepared to allow review of your child's early development in a variety of areas which may not be obviously relevant to the reason your child will be seen. Please take the time to complete each of the following pages as thoroughly as possible, and feel free to add your comments and elaborations on the back of any page. Thank you, in advance, for your time and effort with this form.

~DEMOGRAPHICS~

1. This child's full name is: ____.

2. The child's date of birth is _________________________.

The child's race is _____________________________. The child's sex is ____________________________.

3. This child's present primary address is: ____

____.

The child's present primary phone number is: ____

- ☐ **SEPARATION AND DIVORCE:** If this child's caregivers have separated or divorced any time since the child's birth, please indicate on the **back of this page** (a) dates of separations, reunion, divorce and remarriages, as applicable; (b) the legal conditions of visitation and custody; and (c) your feeling about whether this child was successfully kept out of the middle of the divorce.

- ☐ **FOSTER CARE AND ADOPTION:** If this child is or has been in foster care, or is adopted, please indicate on the **back of this page** (a) dates and reasons for foster care; (b) plan for return to or contact with other caregivers; and/or (c) details and history about natural parents/ reasons for adoption.

4. The name of the person completing this form is: _________________________________. My relationship to the child is _________

____

5. This child is presently in _____ grade.

6. How would you describe this child's physical appearance? (Include a photo if you wish)

____

7. Has this child reached puberty? ☐ Yes ☐ No

~CONCEPTION AND DELIVERY~

8. Was the baby carried to term (9 months)? ☐ Yes ☐ No
If no, baby was carried ___ months.

9. Birth Weight: _____ pounds and _____ ounces

10. Birth Length: _____ inches

Child's Name: ___________________________

11. During pregnancy, the child's natural mother did or experienced which of the following?

- ☐ Smoked Cigarettes (__ packs per day)
- ☐ Drank Alcohol (Amount per day:__________)
- ☐ Was Injured or Fell
- ☐ Had Serious Illness/Surgery
- ☐ Infections, Rashes, or Fever over 101 degrees
- ☐ X-rays, Hospitalizations
- ☐ Ultrasound ("sonogram")
- ☐ Occupational, Chemical, or Other Exposure
- ☐ Used Prenatal Vitamins
- ☐ Gestational Diabetes (Diabetes Mellitus)
- ☐ Eclampsia
- ☐ Placenta Previa
- ☐ Multiple Pregnancies
- ☐ Abnormal Fetal Position
- ☐ Uterine Cramping, Vaginal Bleeding (Spotting), or Vaginal Leakage of Fluid
- ☐ Used Prescription or Non-prescription Drugs. Please Specify: __________________________
- ☐ Used Illegal Drugs. Please Specify: _______________________________
- ☐ Experienced Other Major Stress. Please Specify: ____________________

12. Please indicate which of the following was true of delivery:

- ☐ Vaginal Delivery
- ☐ Cesarean Section
- ☐ Jaundice
- ☐ V-Back
- ☐ Mother Had General Anesthetic
- ☐ Incubator Care
- ☐ Respiratory Distress
- ☐ Meconium Aspiration
- ☐ Prolonged Labor
- ☐ Prolapsed Umbilical Cord
- ☐ Cardiopulmonary Abnormalities
- ☐ Cyanosis (turned blue)
- ☐ Baby Experienced Fetal Distress. Please Specify: ____
- ☐ Infection. Please Specify: ____
- ☐ Other complication. Please Specify:____

13. Did mother or child experience medical complications following delivery? Please elaborate on the back of this page. ☐ Yes ☐ No

14. Mother returned home at _____ days after delivery.
Child returned home at _____ days after delivery.

~INFANCY AND TODDLER YEARS~

(Approximately ages 0 through 2 years old)

15. Did you feel that any of the child's early behaviors were "odd" or "unusual"? ☐ Yes ☐ No

If so, please elaborate on the back of this page.

Did this child experience any of the following:

Place an "x" for all that apply	From age	To age
Colicky		
Feeding Problems		
Sleeping Problems		
Restless		
High Activity Level		
Did not enjoy cuddling		
Frequent Head Banging		
Accident Prone		
Excessively Demanding		
Uncoordinated		
Bed Wetting Problems (enuresis)		
Soiling Problems (encopresis)		
Delay in Talking		

Child's Name: ___________________________

16. Please note the approximate ages at which this child consistently was able to do each of the following:

_____ Sits Alone _____ Stands Unassisted _____ Rolls Over Unassisted

_____ Says First Words _____ Crawled Unassisted _____ Walks Unassisted

_____ Says First Sentences _____ Sleeps Through Night _____ Scribbled with a Crayon

_____ Fears Strangers _____ Full Urine Control _____ Full Bowel Control (Toilet trained)

17. What three adjectives best describe this child during infancy and toddler years?
(examples include: Cuddly; Distant; Curious; Demanding; Loner; Clingy; Hyper; Tense; Loving; Angry)

___________________________, _________________________________, _______________________

18. What was the most difficult part of this child's first two years?

____

19. Did the child experience any illness (e.g., meningitis, encephalitis, chicken pox), injury or prolonged separations during the first two years? ☐ Yes ☐ No

If YES, please elaborate on the back of this page.

~PRESCHOOL YEARS~

(Approximately 2 to 5 years old)

20. Please note the approximate ages at which this child consistently was able to do each of the following:

_____ Tie Shoes _____ Dresses Unassisted _____ Bathes Unassisted

_____ Cleans Up When Asked _____ Brushes Own Teeth _____ Began Day Care

_____ Birth of Next Sibling _____ Began Preschool _____ Shares and Cooperates

_____ Began Kindergarten _____ Writes Own Name _____ Reads Short Words

21. Did this child have a favorite object (toy, animal) which seemed to comfort him or her? ☐ Yes ☐ No

If YES, When did the Child give this object up? _____ years old

22. Describe this child’s adjustment to daycare/nursery school/pre-kindergarten/kindergarten: ___________________
____

23. Describe this child’s reaction to separating from parents/guardians to go to nursery school: __________________
____

Child's Name: __________________________

~Elementary School Years~

(Approximately ages 6 through 11 years old)

HAS THIS CHILD ...?

24. ...had any prolonged absences from school? ☐ Yes ☐ No

25. ...failed or repeated any grade? ☐ Yes ☐ No

…been placed in special education classes? ☐ Yes ☐ No

Full-time special class – From grade _______ to grade _______.

Part-time special class (resource class) – From grade ________ to grade _______.

26. ...had psychological testing of any kind? ☐ Yes ☐ No

27. ...had speech and language or audiological testing? ☐ Yes ☐ No

If yes, from grade _______ to grade _______.

…been diagnosed with a learning disability? ☐ Yes ☐ No

If yes, in what grade was the diagnosis made? ______

28. ... ever been suspended or expelled from any activity? ☐ Yes ☐ No

… ever had legal trouble or been in trouble with the police? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

29. What three adjectives best describe this child's attitude toward school and learning?
(examples: excited; avoidant; bored; resentful; enthusiastic; motivated; disgusted; indifferent)

__________________________, ____________________________, __________________________

30. In elementary school, this child's ...FAVORITE SUBJECT was: ________________________________

... BEST SUBJECT was: ____________________________________

... WORST SUBJECT was: __________________________________

31. Please indicate what EXTRA-CURRICULAR activities this child participated in:

NAME OF ACTIVITY:	AGES WHEN PARTICIPATED:	ENJOYED PARTICIPATING?	SUCCESSFUL IN THIS ACTIVITY?
EXAMPLE: boy scouts	9-11 years old	very much	earned eagle scout

Child's Name: ___________________________

32. Briefly describe this child's religious background and/or involvement and practices: _______________________________

____

33. Briefly describe this child's ethnic and cultural background: ____

____

34. Briefly describe this child's hobbies/interests and leisure/recreational activities: ___________________________________

____

35. Briefly describe this child's strengths/skills: ____

____

36. Briefly describe this child's challenges/areas of difficulty:____

____

37. Briefly describe this child's relationship with current and past teachers: ____

____

38. Briefly describe this child's academic progress (past and present): ____

____

39. During these elementary years, did this child...

a. ... know the names of male and female body parts? ☐ Yes ☐ No

b. ... understand "where babies come from?" ☐ Yes ☐ No

c. ... show any interest in sexual activity? ☐ Yes ☐ No

d. ... act out in a sexualized manner? ☐ Yes ☐ No

e. ... engage in sexual activities with others? ☐ Yes ☐ No

~Family and Home~

40. Please describe this child's family, below.

RELATION	FULL NAME	AGE	LIVE WITH CHILD?	TYPE OF RELATIONSHIP WITH CHILD?	???

Child's Name: __________________________

If anyone else lives in the same home with the child (examples: nanny, roommate), please list here:

41. Do you consider this child's family and/or home environment to be under stress at this time? ☐ Yes ☐ No

42. Does this child have behavior problems at home? ☐ Yes ☐ No
Please elaborate on any YES responses on the back of this page.

43. The child presently lives in: ☐ Trailer ☐ Apartment ☐ Single Family House
☐ Other: ________________________

44. Does this child share a bedroom with anyone? ☐ Yes ☐ No
If YES, please specify whom: __________________________

45. Please list the places where this child has resided since birth. Continue on the back of this page, if necessary:

LOCATION	**BETWEEN AGES:**	**LIVED WITH WHOM?**
1. NOW:		
2.		
3.		

46. Please describe any household chores or responsibilities asked of the child:

Rule or Expectation:	**Reward or Incentive:**	**Punishment or Consequence:**
EXAMPLES: A. Put toys away B. Eat all of supper	A. Earn Allowance B. Get Dessert	A. Toys are Taken Away B. none
1.		
2.		
3.		

Please describe any types of discipline used with this child (who, what, how, where, when administered): _________________

____

~Peer Relationships~

47. Are there same age children in this child's neighborhood? ☐ Yes ☐ No

48. Does this child seek friendships with peers? ☐ Yes ☐ No

49. Is this child sought by peers for friendships? ☐ Yes ☐ No

50. Does this child play with children primarily in her/his own age group? ☐ Yes ☐ No

Child's Name: __________________________

51. Briefly describe any problems this child may have with peers:

____

~Reason for Referral~

To provide the best possible care for your child it is important to be as specific as possible about your concerns and your expectations regarding the outcome of his/her treatment. We appreciate your answering the following questions in your own words. If you need more space, please attach additional pages to the end of this form.

52. Please briefly state the main reason(s) for seeking help at this particular time:

____

____

Please indicate the most troublesome problem you are experiencing with this child at this time:

____

____

Please briefly describe your expectations of your child's care regarding this problem (i.e., goals, treatment, etc.):

____

____

~Family and Patient History~

Does your family or other parent of the child's family have the following ethnic background?

Yes	No	
☐	☐	Southeast Asia, Taiwan, China, or the Philippines
☐	☐	Italy, Greece, or the Middle East
		If yes to the previous two questions, have you, your partner, or your child been tested for thalassemia? ☐ Yes ☐ No
☐	☐	Eastern European (Ashkenazi) Jewish
☐	☐	French Canadian
		If yes to the previous two questions, have you, your partner, or your child been tested for Tay Sachs? ☐ Yes ☐ No
☐	☐	African American, African, or Black
		If yes to the previous question, have you, your partner, or your child been tested for sickle cell anemia? ☐ Yes ☐ No

Have you, the other parent of the child, or anyone in either of your families ever had any of the following? If yes, please explain on the back of this page.

Yes	No		Yes	No	
☐	☐	Down Syndrome	☐	☐	Limb Defects
☐	☐	Other Chromosome Abnormalities	☐	☐	Deafness/Early Onset Hearing Loss
☐	☐	Neural Tube Defect (e.g., spina bifida, anencephaly)	☐	☐	Blindness/Early Onset Vision Loss
☐	☐	Hemophelia or Other Bleeding Disorders	☐	☐	Diabetes
☐	☐	Cystic Fibrosis	☐	☐	Cancer before Age 50
☐	☐	Sickle Cell Anemia	☐	☐	Heart Attack before Age 40
☐	☐	Thalassemia (Mediterranean anemia)	☐	☐	Fragile X
☐	☐	Tay Sach's Disease	☐	☐	Lead Exposure
☐	☐	Muscular Dystrophy	☐	☐	Metabolic Disorder
☐	☐	Neurofibromatosis	☐	☐	Angelman's Syndrome
☐	☐	Huntington's Disease	☐	☐	Tuberous Sclerosis
☐	☐	Other Nerve, Muscle, or Seizure Disorder (e.g., epilepsy)	☐	☐	Anemia

Child's Name: ___________________________

☐	☐	Phenylketonuria (PKU)	☐	☐	Hypothyroidism
☐	☐	Kidney Disease	☐	☐	Hyperthyroidism
☐	☐	Heart Defect (from birth)	☐	☐	Mitochondrial Disease
☐	☐	Cleft Lip and/or Cleft Palate	☐	☐	Lead poisoning

Do you or the other parent have any relatives with mental retardation or developmental delay? ☐ Yes ☐ No
Does anyone in either of your families have a genetic defect or chromosome abnormalities not listed above? ☐ Yes ☐ No
Have you or the other parent had a baby that died shortly after birth or in the first year? ☐ Yes ☐ No
Have you or the other parent had a stillborn child, or three or more first trimester miscarriages? ☐ Yes ☐ No
Are you or the other parent blood-related in any way (i.e., cousins, uncle-niece, etc.)? ☐ Yes ☐ No
Is there any family history that you have concerns about? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

53. Please indicate below which of the following are concerns about this child. Indicate severity of concern in the appropriate box for each item.

AREA OF CONCERN	NOT A PROBLEM/ CONCERN	PROBLEM, BUT NOT SEVERE	LESS SEVERE	MOST SEVERE/ IMPORTANT
TOILETING: Bedwetting, Soiling, Smearing, Regressed to Diapers, Constipation				
EATING: Refuses to Eat, Compulsion to Eat, Picky Eater, Vomiting/Purging, Obesity				
SLEEPING: Difficulties Falling Asleep, Night Waking, Apnea, Sleep-Walking, Terrors				
AGGRESSION: Fighting/Bullying, Setting Fires, Hurting Animals, Destroying Property				
ATTENTION: Inattention, Distractible, Can't Concentrate				
SELF-DESTRUCTIVE: Cuts, Hits, Kicks, Burns, Self, Bangs Head, Risk Taking				
SOCIAL SKILLS: No Friends, Prefers Younger/Older Peers, Loses Friends Quickly				
DEPRESSION: Withdrawal, Isolation, Low Energy, Hopeless, Sad, Helpless				
ACTIVITY LEVEL: Over-Active, Hyper-Active, Out of Control, Inactive, Passive				
CONFUSION: Disoriented, Forgetful, Memory Impairments, Odd Statements				
MOVEMENT PROBLEMS: Twitches, Tics, Paralysis, Seizures, Weakness, Compulsions				
SCHOOL/WORK PERFORMANCE: Falling Grades, Fired or Expelled, Refuses to Attend				
SEXUAL: Preoccupation, Intrusive Ideas, Exposing Self, Touching Others, Role Confusion				
ABUSE/TRAUMA: Victim of Sexual/Physical/Emotional/Verbal Abuse, Accident, Injury				
SEPARATION/LOSS: Death, Divorce, Relocation				
OPPOSITIONAL/DEFIANT: Disrespectful, Defies Authority, Disobedient				
DELINQUENT: Theft, Assault, Police Involvement, Frequent Suspensions, Frequent Fights				
DRUGS AND ALCOHOL: Experimentation, Abuse, Addiction, Peer Pressure				
MEDICAL PROBLEM: Chronic Illness, Terminal Illness, Medication Compliance				

Child's Name: ___________________________

~Medical Status~

54. Has this child ever ...?

a. ... required major surgery of any kind? ☐ Yes ☐ No

b. ... had seizures, black outs or "lost" time? ☐ Yes ☐ No

c. ... lost consciousness or been in a coma? ☐ Yes ☐ No

d. ... had heart or lung diseases? ☐ Yes ☐ No

e. ... had an infectious disease? ☐ Yes ☐ No

f. ... had a head injury? ☐ Yes ☐ No

g. ... required hospitalization? ☐ Yes ☐ No

h. ...had orthopedic problems? ☐ Yes ☐ No

i. ... had dental problems? ☐ Yes ☐ No

j. ... had frequent stomachaches? ☐ Yes ☐ No

k. ...had frequent ear infections? ☐ Yes ☐ No

l. ... had frequent respiratory infections? ☐ Yes ☐ No

m. ... had fever higher than 102 degrees? ☐ Yes ☐ No

n. ... had eye problems? ☐ Yes ☐ No

o. ... had lead poisoning/significant lead exposure? ☐ Yes ☐ No

p. ... had sleep problems (difficulty sleeping)? ☐ Yes ☐ No

q. … received a psychiatric/psychological diagnosis? ☐ Yes ☐ No

r. … received counseling services? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

55. Are this child's immunizations up to date? ☐ Yes ☐ No

56. Does this child complain of chronic physical discomfort? ☐ Yes ☐ No

If YES, please elaborate on the back of this page.

57. Please list the child's current medications:

MEDICATION	DOSAGE	FREQUENCY/DAY	PRESCRIBED BY WHOM?

Child's Name: ___________________________

58. Describe the present medical diagnoses/illnesses for which this child is being treated:

PRESENT	MEDICAL DIAGNOSIS/ILLNESS	TREATING PHYSICIAN	AGE OF INITIAL DIAGNOSIS
☐ Yes ☐ No	Chronic ear infections		
☐ Yes ☐ No	Tube placement		
☐ Yes ☐ No	Epilepsy/Seizures		
☐ Yes ☐ No	Lead poisoning		
☐ Yes ☐ No	Fetal Alcohol Syndrome		
☐ Yes ☐ No	Pica		
☐ Yes ☐ No	Enuresis/Encopresis		
☐ Yes ☐ No	Frequent urinary tract infections		
☐ Yes ☐ No	Acid Reflux		
☐ Yes ☐ No	Chronic constipation/diarrhea		
☐ Yes ☐ No	Sleep Apnea		
☐ Yes ☐ No	Immune dysfunction		
☐ Yes ☐ No	Thyroid problems		
☐ Yes ☐ No	Allergies		
☐ Yes ☐ No	Asthma/Frequent respiratory infections		
☐ Yes ☐ No	Diabetes		
☐ Yes ☐ No	Heart problems		
☐ Yes ☐ No	Autism Spectrum Disorder		
☐ Yes ☐ No	Attention-Deficit/Hyperactivity Disorder		
☐ Yes ☐ No	Behavior Disorder		
☐ Yes ☐ No	Depressive Disorder		
☐ Yes ☐ No	Anxiety Disorder		
☐ Yes ☐ No	Bipolar Disorder		
Other			
Other			
Other			

59. Describe any previous mental health/behavioral health treatment that this child has received:

FROM AGE __ TO AGE __	TREATING PRACTITIONER/AGENCY	NATURE OF PROBLEM	MEDICATION

60. Has your child ever been diagnosed by a professional as being "hyperactive" ☐ Yes ☐ No
or as having an attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?
If yes, at what age was diagnosis made:____________ By whom: ___________________________________

61. Does this child have difficulty with…?

a. ... attention span? ☐ Yes ☐ No

b. ... following directions? ☐ Yes ☐ No

c. ... sitting still? ☐ Yes ☐ No

d. ... excessive movement? ☐ Yes ☐ No

e. ... playing with friends/siblings? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

Child's Name: ___________________________

f. ... distractibility? ☐ Yes ☐ No

g. ... impulsiveness? ☐ Yes ☐ No

h. ... aggressiveness? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

62. Does/Did your child...?

a. ... run in circles, not stopping to rest? ☐ Yes ☐ No

b. ... bang into objects or people? ☐ Yes ☐ No

c. ... constantly ask questions? ☐ Yes ☐ No

d. ... play active games for long periods? ☐ Yes ☐ No

e. ... engage in active social activities (e.g., dancing) for long periods? ☐ Yes ☐ No

f. ... engage in risky behaviors with peers? ☐ Yes ☐ No

g. ... have difficulty attending, except briefly, to a storybook or a quiet task such as coloring or drawing? ☐ Yes ☐ No

h. ... fail to persist very long with a task the child does not want to do such as read an assigned book, homework, or a task that requires concentration such as cleaning something? ☐ Yes ☐ No

i. ... become easily distracted from tasks he/she not desire to preform? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

63. This child is primarily under the medical care of _______________________________(Physician's Name and Specialty).

64. Please indicate here any known family history of physical (example: epilepsy, diabetes) or psychiatric (examples: depression, anxiety, bipolar, learning disability, behavioral problems, addictions) disorder:

RELATION	ILLNESS

65. Please list any allergies that this child has:

____

66. Is this child overweight or underweight? OVERWEIGHT UNDERWEIGHT NO

67. Are there any eating concerns (including poor eating habits, overeating, hoarding, not eating)? ☐ Yes ☐ No

Does your child exhibit any food repulsions? ☐ Yes ☐ No

Does your child exhibit any food compulsions? ☐ Yes ☐ No

Does your child only eat foods of a certain type or texture? ☐ Yes ☐ No

If YES to any of the above, please elaborate on the back of this page.

Child's Name: ___________________________

68. Describe any concerns or problems with balance/coordination:

____

Rate this child on the following skills:

SKILL	GOOD	AVERAGE	POOR
Walking			
Running			
Throwing			
Catching			
Tying shoe laces			
Buttoning			
Writing			

69. Has this child ever been a victim of…?

a. ... physical abuse? ☐ Yes ☐ No

b. ... sexual abuse? ☐ Yes ☐ No

c. ... neglect? ☐ Yes ☐ No

d. …emotional abuse? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

70. List any unusual and/or traumatic family events in this child's life which may have impacted his/her development and current problems (e.g., birth of sibling, any death in the family, divorce, illnesses, frequent school changes).

Incident	Child's age	Comments

Has this child lived away from the family for more than a few days? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

71. Describe your child's primary method of communication at this time: ☐ Gestures ☐ Sign ☐ Other Nonverbal ☐ Verbal

72. Have you observed any form of developmental regression in your child? ☐ Yes ☐ No

If YES answer the following:

a. Age regression observed (list): _________________

b. Describe the regression: ____

____

____

73. Does your child have any unusual sensory sensitivities? ☐ Yes ☐ No

If YES answer the following:

a. Over sensitive to stimuli/things in the environment (describe): _____________________

____

b. Unusually interested in stimuli/things in the environment (describe): ________________

____

Child's Name: ___________________________

74. Does your child have any abnormal eating or sleeping habits (describe): ____
____

75. Does your child display unusual fearfulness of harmless object (describe): ____

76. Does your child seem to have a lack of fear for real dangers (describe): ____
____

77. Does your child engage in any self-injurious behaviors (e.g., self biting, head banging) (describe): ___________________________
____

78. Does your child...

a. cuddle like other children? ☐ Yes ☐ No

b. look at you when you are talking or playing? ☐ Yes ☐ No

c. smile in response to a smile from others? ☐ Yes ☐ No

d. engage in reciprocal, back-and-forth play? ☐ Yes ☐ No

e. play simple imitation games, such as pat-a-cake or peek-a-boo? ☐ Yes ☐ No

f. show interest in other children? ☐ Yes ☐ No

g. point with his or her finger? ☐ Yes ☐ No

h. gesture (e.g., nod yes and no)? ☐ Yes ☐ No

i. direct your attention by holding up objects for you to see? ☐ Yes ☐ No

j. show things to people? ☐ Yes ☐ No

k. give inconsistent response to his or her name (or to commands)? ☐ Yes ☐ No

l. use rote, repetitive, or echolalic speech? ☐ Yes ☐ No

m. memorize strings of words or scripts (e.g., phrases from movies, cartoons)? ☐ Yes ☐ No

n. have repetitive, stereotyped, or odd motor behavior? ☐ Yes ☐ No

o. have preoccupations or a narrow range of interests? ☐ Yes ☐ No

p. attend more to parts of an object (e.g., the wheels of a toy car)? ☐ Yes ☐ No

q. have limited or absent pretend play? ☐ Yes ☐ No

r. imitate other people's actions? ☐ Yes ☐ No

s. play with toys in the same exact way every time? ☐ Yes ☐ No

t. appear strongly attached to a specific unusual object(s)? ☐ Yes ☐ No

Child's Name: ___________________________

~Other Comments~

79. Is there any current or past court involvement or other agency involvement? ☐ Yes ☐ No

Please elaborate on any YES responses on the back of this page.

80. Write any additional remarks regarding this child's difficulties below.

____

____

____

____