Pathways to Wellness
A Southern California Relationship Center
3505 Cadillac Avenue
Building O, Suite 109
Costa Mesa, California 92626
714-432-9856
Fax - 714-432-7075
Pathways2wellness.com

Nancy Young, PhD PSY #11961
Stephenie Champlin, LCSW #74243
Adrienne Clements, LMFT #105630
Jessica Hassen, LMFT #106732
Rupa Ward, LMFT #115736
Reza Ghaboosi, LMFT #120222
Lisa Strawn, AMFT #132727
Michelle Pando, AMFT #134544

Today's Date:_____

Developmental Questionnaire for Children

Minor Client's Name: _____ DOB:_____ Age:_____

Sex: Male _____ Female_____ Grade Level:_____

School:_____ Teacher:_____

Emergency Contact:

_____

Name Relationship Phone Number

Parent's Name:_____ DOB: _____ Age:_____

Address: _____City, State, Zip:_____

Home: (_____)_____Work: (_____)_____Cell:(_____)_____

Do you have/use Text Messaging: __yes __no __what?

Email address: _____

SS#:_____(only needed for the parent responsible for payment)

Parent's Name:_____ DOB:_____Age:_____

Address: _____City, State, Zip:_____

Home: (_____)_____Work: (_____)_____Cell:(_____)_____

Do you have/use Text Messaging: __yes __no __what?

Email address: _____ SS#:_____

OFFICE POLICIES:

Fees: Clients are expected to pay the standard fee of $175.00 per 50-minute* session at the end of each session unless other arrangements have been made. *Sessions lasting longer than 60 minutes will be charged at the appropriate fraction of time at $175.00 per hour. ***It is important to note that if additional time is NOT covered by insurance, payment is the sole responsibility of the client.***

Communication outside of sessions, site visits, report writing and reading, consultation with other professionals, release of information, reading records, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise.

Payment for Services: Payment of fees MUST be made in full at the time services are rendered unless prior arrangements have been made. A minimum $30.00 service charge will be made for any checks which are returned by the bank.

Insurance Reimbursement: We are OUT-OF-NETWORK for all insurance providers. We do accept Medicare with supplemental insurance. We do not accept HMO plans. Clients who carry insurance should remember that professional services are rendered, charged to, and paid for by the client and not the insurance company. Any billing we do for the client is as a courtesy and can only be done through PPO/POS plans with OUT-OF-NETWORK coverage. A "superbill" receipt can be provided to you, which can be sent to your insurance company for reimbursement.

Cancellation: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48-hour notice is required for rescheduling or cancellation of appointments. The full fee will be charged for missed sessions without such notification. Clients who miss appointments and fail to inform the office 48 hours prior, are required to pay for missed sessions and for future sessions in advance in order to secure desired appointments.

Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child or elder abuse; where there is a reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm her/himself unless protective measures are taken. Disclosures may also be required pursuant to a legal proceeding. Psychology, Associate Clinical Social Worker, and Associate Marriage and Family Therapy interns are supervised by Nancy D. Young, Ph.D. a licensed clinical psychologist, who will have access to your confidential records and information for the purposes of supervision and quality assurance.

Emergency procedure: If an emergency arises and you need immediate assistants PLEASE CALL 911.
If you need to contact your clinician between sessions, please leave a message on her/his confidential Voice Mail or via email.

I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES. I AGREE TO THE ABOVE PROVISIONS. I AUTHORIZE TREATMENT AND AGREE THAT I (CLIENT) AM RESPONSIBLE FOR ANY AND ALL CHARGES.

Signed: _____Date: _____

FAMILY HISTORY

Biological History of the child (for example: lives with 2 biological parents; reproductive technology-in-vitro by donor; adoption; divorce of biological parents):

_____

_____

_____

If child is not with biological parents, please state the circumstances: _____

_____

Marital status of parents: _____

For parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements.) Who has legal custody?

_____

_____

If adopted, does child know of adoption? Yes No

What age was your child at the time of adoption? _____

If reproductive technology was engaged, does child know of the history? _____

What is the current living situation? (Please include all members living in the household.)

_____

_____

What significant events has your child's family experienced? (for example: moves, separations, divorces, blended family, deaths) Please elaborate and use dates.

_____

_____

_____

Sibling's Name: _____ DOB: _____

School: _____ Grade Level: _____ Teacher: _____

Child's living arrangement: _____

Sibling's Name: _____ DOB: _____

School: _____ Grade Level: _____ Teacher: _____

Child's living arrangements: _____

Parent Name: _____ Age: _____

What does the child call you? _____

Please circle one:

biological parent step parent foster parent guardian adoptive parent

Occupation: _____ Hours per week: _____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past? _____

_____

Medications currently prescribed? _____

_____

History of psychiatric treatment or counseling? _____

_____

Current alcohol or drug use (how often, intoxication frequency)? _____

_____

History of alcohol or drug abuse? _____

_____

Close relatives with drug/alcohol problems or mental illness? _____

_____

History of arrests? _____

_____

Parent Name: _____ Age:_____

What does the child call you? _____

Please circle one:

biological parent step parent foster parent guardian adoptive parent

Occupation: _____ Hours per week: ____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past? _____

_____

Medications currently prescribed? _____

_____

History of psychiatric treatment or counseling? _____

_____

Current alcohol or drug use (how often, intoxication frequency)? _____

_____

History of alcohol or drug abuse? _____

_____

Close relatives with drug/alcohol problems or mental illness? _____

_____

History of arrests? _____

_____

Other Step-Parent or Guardian Name: _____Age: _____

What does the child call you? _____

Relation to the child? _____

Occupation: _____Hours per week: _____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past? _____

_____

Medications currently prescribed? _____

_____

History of psychiatric treatment or counseling? _____

_____

Current alcohol or drug use (how often, intoxication frequency)? _____

_____

History of alcohol or drug abuse? _____

_____

Close relatives with drug/alcohol problems or mental illness? _____

_____

_____

History of arrests? _____

_____

MEDICAL HISTORY OF THE CHILD

Has child ever had any serious illnesses, ear infections, allergies, accidents, or operations?

_____

_____

_____

Please describe and specify child's age at the time (include any present illnesses): _____

_____

_____

Pediatrician's name and address: _____

_____

Phone: _____ Currently on medication? If yes, what? _____

_____

Has child been immunized? Up to date on immunizations? _____

_____

Has child ever had psychiatric or other treatment modalities? If yes, please give details and names of the psychiatrist, etc. _____

_____

_____

_____

_____

SCHOOL AND AGENCY INFORMATION

Did/does child attend preschool? _____ Beginning of what age?_____

Were there any problems? _____

_____

Does child have behavior problems now in school? _____

_____

Does child have learning problems in school? _____

_____

If child has been kept back or put ahead in school, please explain: _____

_____

_____

_____

If child has been in special classes, please explain: _____

_____

_____

Since what age? _____

If child has ever been excluded from school, explain when and why: _____

_____

_____

Are there any other agencies involved with the family? (DCS, Child Welfare, Court Appointed Lawyer, etc.)_____

HISTORY OF PROBLEM

In your own words, please describe any present difficulties that child is having or that you may be having as parent(s): _____

_____

_____

_____

What methods were used to help with these problems?

_____

_____

_____

_____

What are your child's strengths? Weaknesses? _____

_____

_____

What are your strengths and weaknesses as parent(s)? _____

_____

_____

In what way do you think I can help you? _____

_____

_____

_____

_____

Does your child currently have a diagnosis? _____

Who made the diagnosis? _____ Date _____

Has your child been formally tested by a school district or privately? (Date, assessment name, practitioner's name or school district)

_____

_____

_____

CHILD'S DEVELOPMENTAL HISTORY

A. Period during Pregnancy

Was the child planned? _____

When was pregnancy discovered? _____

How did the biological mother feel about having child? _____

_____

Gender preference? _____

Did mother work during pregnancy? _____ How long? _____

Did mother have any medical or emotional problems during pregnancy (for example, diabetes, bedridden, unusual nervousness, depression)? _____

_____

Did mother receive prenatal care? Starting when /how often? _____

_____

How did the biological father feel about having child? _____

Gender preference? _____

Did father have any medical or emotional problems or stressors during the course of mother's pregnancy?

_____

_____

B. Details of Labor and Delivery

Vaginal or C-section birth? _____ Where was child born? _____

Any complications in labor or delivery? _____

_____

Did mother experience any "blues" after child's birth?

Describe:_____

_____

C. Postnatal

Weight of child at birth: _____Was child full term (9 months)? _____

Any complications after child was born? (difficulty breathing, low Apgar score, jaundice)

_____

_____

_____

Did mother have help at home after delivery? For how long? _____

_____

_____

During child's first year, was there anything (even if it had nothing to do with child) that caused primary parent unhappiness or anxiety or that placed her under great strain? Other parent? _____

_____

_____

How was caretaking for the infant handled in the home?_____

_____

What part did other parent take in child's care? (diapering, bathing, feeding, etc.) _____

_____

_____

After child's birth, how soon did the primary parent return to work? _____

How many hours per week? _____

If mother was working, who had primary caretaking responsibility? _____

_____

Who currently cares for the child if parents are away? (Please include history of caregivers other than parents from birth to the present) _____

_____

_____

Was child ever separated from both parents? _____ One parent? _____

Describe circumstances (reason, child's age at the time, and how long): _____

_____

D. Feeding

Breastfed? _____ When was child weaned? _____ Why did weaning occur at that time? _____

Bottle-fed? _____ When was child weaned? _____ Why did weaning occur at that time? _____

Were there any feeding problems? (colic, reflux, allergies) _____

_____

_____

Any thumb or pacifier sucking? For how long? _____

_____

E. Sleep Patterns

What were the sleeping arrangements during the child's first 6 months? First year?

_____

_____

Were there any sleeping problems? If yes, please explain: _____

_____

_____

Please describe circumstances and arrangements when child and parent[s] have slept in the same room or bed._____

_____

_____

Present sleeping patterns and arrangements: _____

_____

_____

F. Development of Motor & Sensory Regulating

Was child ever perceived as too active or too quiet? Please describe: _____

_____

_____

_____

_____

At what age did child begin to sit? _____ Stand? _____ Walk? _____ Who took primary responsibility for toilet training? _____

At what age did bladder training begin?_____

When completed for day? _____ For nights? _____ Method used? _____

_____

At what age did bowel training begin? _____ Completed? _____ Method? _____

_____

Was toilet training ever a problem? _____

_____

Is this a problem at present? _____

Is child primarily right or left handed? _____

Did/does infant ever cry for extended periods? _____ If yes, how did/do you respond?

_____

_____

F. Speech Development

At what age did child first begin to babble and utter own words in short (2 or more word) sentences?

_____

_____

If there have been any of the following speech difficulties, please check:

Does not talk _____ Lisping _____ Delayed speech _____

Repeating syllables _____ Mispronounced words _____ Stuttering _____

Other, please describe: _____

Has child ever had speech therapy? With whom? _____

_____

G. Sexual Development

Has child expressed curiosity about any sexual matters to a parent? _____

About what? _____

_____

_____

Has child been given information by a parent in any of the following areas? Please check.

Difference between boys/girls _____ How a woman becomes pregnant _____

How child develops and is born _____ Menstruation _____

Birth control _____ Intercourse _____

H. Peer Interests

Does child have trouble making friends? Please describe: _____

_____

_____

Does child make friends mostly with children his or her own age? _____

Younger? _____ Older? _____

Describe any special interests or hobbies: _____

_____

_____

I. Other

Has your child received a diagnosis before? If so, please indicate what provider gave the diagnosis and the date. _____

Has your child had any formal or informal assessments by previous therapists, doctors, school, etc? Please provide copies and details._____

_____

Has your child utilized a 504 Plan or IEP in school? If so, please provide a copy._____

How is discipline usually handled with child? _____

_____

_____

Do you have any other questions, concerns, comments on questionnaire or additional information you would like me to know? _____

_____

_____

_____