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DEVELOPMENTAL HISTORY AND BACKGROUND

Patient's name

Patient's date of birth

Name of person completing form

Relationship to patient

FAMILY MEMBERS

Father's name

Date of birth

Last Grade completed

Occupation

Employer

Mother's name

Date of birth

Last Grade completed

Occupation

Employer

Are Mom and Dad still married?

- [ ] Yes
- [ ] No

SIBLINGS

Names | Gender | Date of birth

OTHERS LIVING IN THE HOUSEHOLD

Names | Gender | Date of birth

FAMILY MEDICAL HISTORY

- [ ] Diabetes
- [ ] Thyroid Problems
- [ ] Heart Disease
- [ ] Hypertension
- [ ] Allergies
- [ ] Cancer
- [ ] Asthma
- [ ] Tuberculosis
- [ ] Epilepsy
- [ ] Learning Disabilities
- [ ] Mental Retardation
- [ ] Attention Difficulties
- [ ] Anxiety
- [ ] Obsessions/Compulsions
- [ ] Alcoholism
- [ ] Drug Use
- [ ] Depression
- [ ] Other Medical/Mental Conditions

Please elaborate on any checked items above

FAMILY MEDICAL HISTORY

Is your child adopted?

- [ ] Yes
- [ ] No

If you answered yes above, please describe the biological mother's pregnancy (include any complications)

Please check if any of the following occurred

- [ ] Toxemia
- [ ] Rh factor incompatibility
- [ ] Breech
- [ ] Eclampsia
- [ ] Hypertension

Please check and indicate the frequency of use during pregnancy if applicable

- [ ] Beer or Wine — How often _____
- [ ] Hard Alcohol — How often _____
- [ ] Coffee or Caffeinated Beverages — How often _____
- [ ] Cigarettes — How often _____
- [ ] Marijuana — How often _____

Other | How often

Please check and indicate the frequency of use during pregnancy if applicable

- ☐ Valium (Xanax, Librium) How often _____
- ☐ Tranquilizers How often _____
- ☐ Seizure Medication How often _____
- ☐ Antidepressants How often _____
- ☐ Antibiotics How often _____
- ☐ Sleep Medication How often _____

Other | How often

PREGNANCY QUESTIONS

Was your child full-term?

- ☐ Yes
- ☐ No

Please describe your labor and delivery (complications. medications, etc.)

Describe your child's condition at birth (height, weight, APGAR scores, etc.)

CHILD'S INFANCY

Describe your child as an infant

Response to touch and cuddling

Eating behaviors

Was child colicky?

Sleeping behaviors / routine (including naps and night time)

Describe how alert your infant was

Was your infant sociable with others, fearful of others?

Was it easy to set and follow routines with your child as an infant?

Describe any health problems during infancy

List age of the following developmental milestones and any notable details:

SMILE

ROLLING OVER

SITTING WITHOUT SUPPORT

CRAWLING

GRASPING OBJECTS

WALKING

TOILET TRAINED

Describe your child as a toddler (easy or difficult, energetic, inquisitive, defiant, independent, clingy)

LANGUAGE DEVELOPMENT

Describe your child's speech and language

At what age did your child understand spoken words?

When did your child say his/her first words?

At what age did your child begin combining two or three words together?

Does your child have difficulty organizing his/her ideas?

- [ ] Yes
- [ ] No

If yes to above, how so?

Can he/she retell a story in logical order?

- [ ] Yes
- [ ] No

Describe any developmental concerns

MEDICAL HISTORY

Describe your child's general health

Does your child have any hearing or vision problems (if so please describe)

Describe your child's gross (running, biking, sports) and fine (writing,tying shoes, handling small objects) motor coordination

Does your child have any chronic health problems (Asthma, diabetes, heart condition?)

Please note if your child has had any of the following condition and at what age

☐ Mumps	Age _____	☐ Chicken Pox	Age _____
☐ Measles	Age _____	☐ Whooping Cough	Age _____
☐ Scarlet Fever	Age _____	☐ Rubella	Age _____
☐ Pneumonia	Age _____	☐ Encephalitis	Age _____
☐ Otitis Media	Age _____	☐ Lead Poisoning	Age _____
☐ Seizures	Age _____	☐ Allergies	Age _____

Other | What Age?

Has your child received his/her vaccinations/immunizations?

Describe any accidents or falls your child has had

Describe any hospitalizations or surgeries your child has had

SCHOOL HISTORY

At what age did your child start kindergarten?

Was he/she in daycare? If so from what ages?

Has your child ever skipped grades? If yes, which ones?

In the spaces below describe your child's adjustment to school, interests in school, and any strengths or weaknesses.

Please note the name of the school and years the child attended the following :

Preschool:

Kindergarten:

Grades 1 - 3:

Grades 4 - 6:

Junior High School:

High School:

Describe any academic subjects that are difficult for your child

Has he/she ever been evaluated by a Child Study Team?

- [ ] Yes
- [ ] No

Was a classification recommended or were any accommodations made?

How easily does your child make friends?

SOCIAL DEVELOPMENT

Describe what your child is like at home (activity level, behavior, ability to entertain self, relationships)

How easily does your child make friends?

Do these friendships last?

Does your child have many friends?

Are they the same age or younger?

How well does your child get along with his/her friends?

What are your child's interests and hobbies? Any special skills? Sports?

TREATMENT HISTORY

Has your child ever been referred to counseling or other psychological services before?

- [ ] Yes
- [ ] No

What were the presenting problems?

What was the outcome of treatment?

CURRENT CONCERNS

Describe the primary concerns that led you to treatment for your child at this time

When did these issues begin and how severe are the problems?

Have there been any important events (divorce, death, illnesses, accidents) in your family that may be affecting your child's emotional health or school performance?

Is your child aware of your concerns?

- [ ] Yes
- [ ] No

If so how would he/she describe the problem?

When you need to set limits with your child or when he/she does not follow the rules, what intervention strategies have you found to be effective?

Do you have concerns about alcohol or drug use with your child?

Any concerns about eating disorders with your child?

What would be the most difficult adjustment in your child's life to date?

_____ _____

Signature of patient/guardian Date