DEVELOPMENTAL HISTORY FORM

The purpose of this form is to obtain a detailed understanding of your child's growth and development. Please answer all of the questions below, to the best of your ability. If a question does not apply to your particular situation, leave it blank.

IDENTIFYING INFORMATION

Child's name: _____ Today's date: _____

Child's date of birth: _____ Age: _____ Sex: Male ☐ Female ☐

Home address: _____

_____

Home phone number: _____ Parent's cell number: _____

PRESENTING PROBLEMS

Why are you seeking this evaluation of treatment? _____

_____

When did these problems begin? _____

Who referred you? _____

What are your goals for this evaluation or treatment? _____

_____

_____

PARENTS, SIBLINGS & OTHERS IN THE HOME

Mother's name: _____ Mother's age: _____

Address: _____

Home phone: _____ Cell number: _____ Work phone: _____

Occupation: _____ Full-time ☐ Part-time ☐

Education/Highest grade completed: _____

Father's name: _____ Father's age: _____

Address: _____

Home phone: _____ Cell number: _____ Work phone: _____

Occupation: _____ Full-time ☐ Part-time ☐

Education/Highest grade completed: _____

Does your child have stepparents? No ☐ Yes ☐

If yes, please complete the following information:

Name(s): _____

Relationship(s) to the child: _____

Address(es)/phone(s): _____

_____

Is the child adopted or being raised by persons other than his/her biological parents? No ☐ Yes ☐

If yes, explain: _____

Name of siblings	Age	Gender	Lives at home?	Nature of relationship with child?
1. _____	___	_____	_____	_____
2. _____	___	_____	_____	_____
3. _____	___	_____	_____	_____
4. _____	___	_____	_____	_____

Please list any others living in the household:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

FAMILY CIRCUMSTANCES

Who cares for the child when the parents or caregivers are at work or gone? _____

With whom does the child currently live? _____

Are the parents divorced or separated? No ☐ Yes ☐

If yes, who has custody? _____

How often does the noncustodial parent see the child? _____

Family's religious affiliation (optional): _____

How frequently does this child see his/her grandparents? _____

Has the family recently experienced any unusual or stressful events? No ☐ Yes ☐

If yes, explain: _____

PREGNANCY

Did the mother receive prenatal medical care? No ☐ Yes ☐

If yes, what kind? _____

Length of pregnancy? _____

Did the mother experience any emotional or medical difficulties during the pregnancy? No ☐ Yes ☐

If yes, explain: _____

Length of labor: _____ hours APGAR scores: _____ _____

Birth weight: _____ lbs. _____ oz. Length: _____ inches

DEVELOPMENT

What this child Brest-fed ☐ Bottle-fed ☐ Age weaned: _____

Did the child experience any of the following problems during infancy or toddlerhood? If yes, please explain.

Colic	No ☐ Yes ☐
Excessive crying	No ☐ Yes ☐
Delayed language development	No ☐ Yes ☐
Unclear speech	No ☐ Yes ☐
Eating problems	No ☐ Yes ☐
Delayed fine motor skills	No ☐ Yes ☐
Delayed Gross motor skills	No ☐ Yes ☐

At what approximate age did your child begin exhibiting the following behaviors?

Crawled: _____ Sat alone: _____

Walked independently: _____ Spoke first words: _____

Spoke sentences: _____ Was toilet trained: _____

For an adolescent, please indicate the following:

Age of onset of puberty: _____ Age at first mensuration (for girls): _____

Which hand does your child use for:

Writing: Right ☐ Left ☐ Eating: Right ☐ Left ☐ Throwing: Right ☐ Left ☐

Other: _____ Right ☐ Left ☐

Has your child been a victim of abuse? No ☐ Yes ☐

If yes, please explain: _____

MEDICAL & PSYCHIATRIC HISTORY

Name of child's primary care physician: _____

Address: _____

_____

Phone: _____ Fax number: _____

Date of most recent physical exam: _____ Results: _____

Date of most recent dental exam: _____ Results: _____

Date of most recent vision exam: _____ Results: _____

Date of most recent hearing exam: _____ Results: _____

Has the child experienced any of the following medical problems? If yes please explain.

Frequent colds	No ☐ Yes ☐	_____
Frequent ear infections	No ☐ Yes ☐	_____
Asthma	No ☐ Yes ☐	_____
Muscle pain	No ☐ Yes ☐	_____
Skin problems	No ☐ Yes ☐	_____
Repetitive behaviors (head banging, rocking, etc.)	No ☐ Yes ☐	_____
Allergies	No ☐ Yes ☐	_____
Vision problems	No ☐ Yes ☐	_____
Does your child wear glasses?	No ☐ Yes ☐	_____
Hearing problems	No ☐ Yes ☐	_____
Cerebral palsy	No ☐ Yes ☐	_____
Lead poisoning	No ☐ Yes ☐	_____
Seizures	No ☐ Yes ☐	_____
Congenital problems	No ☐ Yes ☐	_____
Hospitalizations for medical issues	No ☐ Yes ☐	_____
Operations	No ☐ Yes ☐	_____
Serious accidents	No ☐ Yes ☐	_____

Please list any other health concerns: _____

Medication

Is the child currently taking any kind of medication(s)? No ☐ Yes ☐

If yes, indicate name, dose and reason for medication: _____

_____

_____

Is the child experiencing any side effects from the medication(s)? _____

Alcohol or Drug Use

Does the child use alcohol or drugs? No ☐ Yes ☐

If yes, which? Tobacco ☐ Alcohol ☐ Illicit substances ☐ Prescription medications ☐ Other: _____ ☐

If yes, please explain: _____

Previous Evaluations

Has the child ever had any of the following evaluations? If yes, please indicate the name of the examiner, date of examination and reason for exam.

Psychological or psychiatric evaluation? No ☐ Yes ☐

If yes, name of examiner: _____ Date of evaluation: _____

Reason for evaluation: _____

Neuropsychological evaluation? No ☐ Yes ☐

If yes, name of examiner: _____ Date of evaluation: _____

Reason for evaluation: _____

Neurological evaluation? No ☐ Yes ☐

If yes, name of examiner: _____ Date of evaluation: _____

Reason for evaluation: _____

Treatment History

Has the child ever received counseling or psychiatric treatment? No ☐ Yes ☐

If yes, indicate dates, name of treating professional, reason for treatment, and effectiveness of treatment: _____

_____

_____

Family Health

Mother's present health: _____

Father's present health: _____

Has anyone in the child's family experienced a mental, psychological, or academic problem, such as mental retardation, learning disabilities, schizophrenia, depression, epilepsy, or a bipolar disorder? No ☐ Yes ☐

If yes, explain: _____

SOCIAL HISTORY

How does the child relate to other children? _____

Does the child prefer to play with younger or older children? No ☐ Yes ☐

If yes, indicate which (younger or older) and explain: _____

Does the child have a best friend? No ☐ Yes ☐

How many friends does the child have? _____

Are you concerned about the types of friends the child has? No ☐ Yes ☐

If yes, explain: _____

RECREATIONAL INTERESTS

Does the child participate in sports or other recreational activities outside of school? No ☐ Yes ☐

If yes, describe: _____

What does the child like to do in their free time? _____

Have the child's interests in these activities recently changed? No ☐ Yes ☐

If yes, explain? _____

What are your family's favorite activities? _____

BEHAVIORAL SYMPTOMS

Does the child have any difficulties with the following problems? If yes, please explain.

Has trouble meeting new people, is shy or withdrawn	No ☐ Yes ☐	_____
Is overly anxious	No ☐ Yes ☐	_____
Seems sad or depressed	No ☐ Yes ☐	_____
Has thoughts of suicide	No ☐ Yes ☐	_____
Refuses to comply with adults' requests or violates parental rules	No ☐ Yes ☐	_____
Has conduct problems	No ☐ Yes ☐	_____
Is physically cruel to other people	No ☐ Yes ☐	_____
Is physically cruel to animals	No ☐ Yes ☐	_____
Is inattentive	No ☐ Yes ☐	_____
Problems concentrating	No ☐ Yes ☐	_____
Is restless	No ☐ Yes ☐	_____
Makes careless mistakes	No ☐ Yes ☐	_____
Has trouble playing quietly	No ☐ Yes ☐	_____
Has frequent mood shifts	No ☐ Yes ☐	_____
Frustrates easily	No ☐ Yes ☐	_____
Has difficulty managing anger	No ☐ Yes ☐	_____
Has eating problems	No ☐ Yes ☐	_____
Has fears/phobias	No ☐ Yes ☐	_____
Has hallucinations	No ☐ Yes ☐	_____
Has experienced trauma	No ☐ Yes ☐	_____

Has the child ever experienced difficulty with the law? No ☐ Yes ☐

If yes, explain: _____

Has the child ever run away from home overnight? No ☐ Yes ☐

If yes, how many times? _____ Describe circumstances: _____

EDUCATIONAL STATUS & HISTORY

Current Status

Name of current school: _____ Grade: _____

Type of school: Private ☐ Public ☐ Home-schooled ☐ Other ☐: _____

Teacher(s): _____

Does the child currently receive any special education services? No ☐ Yes ☐

If yes, please specify: _____

What grades does the child currently receive? _____

Is this a change from previous years? No ☐ Yes ☐

If yes, explain: _____

Did this child repeat a grade? No ☐ Yes ☐ If yes, which one(s): _____

Are there any concerns the teachers have expressed to you, or you have, about the child's behaviors or achievement in school? _____

_____

_____

School History

Preschool? No ☐ Yes ☐ If yes, at what age? _____ For how many hours/days? _____

Any problems in preschool? No ☐ Yes ☐ If yes, explain: _____

Did the child have difficulty or receive any special education services in any of the following grades? If so, please explain.

Kindergarten	No ☐ Yes ☐	_____
Grades 1-3	No ☐ Yes ☐	_____
Grades 4-5	No ☐ Yes ☐	_____
Grades 6-8	No ☐ Yes ☐	_____
High school	No ☐ Yes ☐	_____

Does the child dislike going to school? No ☐ Yes ☐

If yes, why? _____

What are the child's favorite subjects? _____

What are the child's least favorite subjects? _____

What is the child's approach to his/her school work? Disorganized ☐ Organized ☐ Irresponsible ☐ Responsible ☐

Procrastinates ☐ Other ☐: _____

WORK HISTORY

Does the child have a job, or is the child involved in a vocational program? No ☐ Yes ☐

If yes, who is the child's employer? _____

Child's position: _____ Hours worked per week: _____

Does the child have chores? No ☐ Yes ☐

If yes, describe what and how often they do the chore: _____

_____

If there are any other issues you would like to share please do so in the area below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank-you for your assistance in the gathering of this information.

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