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Child Developmental History Record

Preliminary Information

A. Child's name: _____ Birthdate: _____ Age: _____

B. Person(s) completing this form: _____Today's date: _____

C. Relationship to this child:_____

D. Address:_____

E. School:_____ Grade:_____

F. Reason for seeking help at this time:_____

G. Who referred you to my practice:_____

H. What kind of services are you seeking? (for example, therapy, psychological testing, parenting consultation)_____

Family Composition

A. Mother's name: _____ Birthdate:_____ Home phone: _____
Address: _____
Currently employed: __ No _ Yes, as: _____ Work phone: _____

B. Father's name: _____ Birthdate: _____ Home phone: _____
Address: _____
Currently employed: __No __Yes, as: _____ Work phone: _____

C. Parents are currently __ Married __ Divorced __ Remarried __ Never married _ Other: _____

D. Child's custodian/guardian is: _____

E. Stepparent's name: _____Birthdate_____ Home phone: _____
Address: _____
Currently employed: _ No _Yes, as: _____ Work phone: _____

F. Any other guardian?_____Birthdate_____ Home phone: _____
Address: _____
Currently employed: _ No _Yes, as: _____ Work phone: _____

G. Please list all brothers and sisters, and any other children/adults living with the family:
_____

H. Has the child experienced any deaths in the family or other similar losses:_____
_____

Developmental History

Pregnancy and delivery

A. Was your child adopted?_____

B. Prenatal medical illnesses and health care: _____

C. Were cigarettes, alcohol or other drugs used during pregnancy?_____

D. List any prescribed or over the counter medications taken during pregnancy (include vitamins)_____

E. Length of pregnancy_____

F. Was the child premature? _____ Weight and length at birth: _____ _____

G. Mother's age at the time of the birth of this child_____

H. Please list any complications that occurred during the pregnancy

___High blood pressure
___Toxemia
___Emotional problems
___Anemia
__ Hospitalizations during pregnancy_____
___Maternal injuries_____
___Other_____

I. Any problems or complications at birth?_____

J. Did baby cry immediately?_____

K. Did baby need help with breathing?_____

L. Child's and mother's condition at birth_____

<u>The first few months of life</u>

A. Breast-fed?_____ If so, for how long?_____

B. Any allergies? _____

C. Were there any difficulties during the baby's first few months? If yes, please check and describe:

_____feeding _____sleeping _____alertness _____activity level
_____movement _____jaundice _____Other:_____

D. Sleep patterns or problems: _____
_____
_____

E. Personality: _____
_____
_____

<u>Developmental Milestones</u>: At what age did this child do each of these?

Sat without support: _____
Crawled:_____
Walked without holding on: _____
Ate with a fork:_____
Stayed dry all day:_____
Stayed dry all night: _____
Did bed-wetting occur after toilet-training? Yes No If yes, until what age?_____
Did bed-spoiling occur after toilet training? Yes No If yes, until what age?_____
Were there any medical reasons for bed-wetting? Yes No If yes, please describe
_____

Dressed self completely: _____

Age when child said first word understandable to strangers: _____
Age when child said first sentence understandable to a stranger: _____
Any speech, hearing, or language difficulties? _____
_____
During the child's first four years, were there any difficulties in the following areas?

Eating	Yes	No
Motor Skills	Yes	No
Sleeping too much	Yes	No
Sleeping too little	Yes	No
Temper tantrums	Yes	No
Failure to thrive	Yes	No
Separating from parents	Yes	No
Excessive Crying	Yes	No
Colic	Yes	No

Temperamental factors: Please describe your child's temperament

High Activity level, unusually active	Yes	No
Impulsive	Yes	No
Fearful/Inhibited	Yes	No
Anxious in new situations or new people	Yes	No
Accident prone	Yes	No
Short attention span	Yes	No
Irritable	Yes	No
Poor adaptation to change	Yes	No
Colic	Yes	No
Frequent temper tantrums	Yes	No
Eating Problems	Yes	No
Sleep Problems	Yes	No
Clumsiness	Yes	No
Rigid, tense instead of cuddly	Yes	No

Is there anything else that may describe your child as a toddler:

_____
_____

Environmental Risk Factors: Did your child experience any of the following:

Significant loss or separation from a loved one	Yes	No
Sexual Abuse	Yes	No
Physical Abuse	Yes	No
Emotional Abuse	Yes	No
Violence in the family	Yes	No
Neglect	Yes	No
Extreme family stress	Yes	No
Economic problems/financial stress	Yes	No
Poor diet	Yes	No
Exposure to heavy metals (lead)	Yes	No

Were there any other traumas during the child's childhood? If yes, please describe:
_____
_____

D. Health

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

Did your child experience any of the following:

Allergies	Yes	No
Asthma	Yes	No
Ear infections	Yes	No
Encephalitis	Yes	No
Meningitis	Yes	No
Fainting Spells/blackouts	Yes	No
Careless accidents/frequent falling	Yes	No
Frequent emergency room visits	Yes	No
Broken bones	Yes	No
Hospitalized for any reason	Yes	No
Loss of consciousness	Yes	No
Seizures	Yes	No
Speech problems	Yes	No
Anemia	Yes	No
Heart problems	Yes	No
Breath holding spell	Yes	No
Coordination problems	Yes	No
Staring spells	Yes	No
Swallowing/sucking problems	Yes	No

Has the child ever been on long-term medication (more than 6 months)? Yes No
If yes, please explain_____

Has this child ever had a neurological exam? Yes No
If yes, please explain_____

Has your child had x-rays or special x-rays such as: CAT Scan_____ MRI_____ Other_____

Has this child ever had a psychiatric or psychological exam? Yes No
If yes, please explain_____

Has this child ever seen a psychologist, counselor or therapist for counseling? Yes No
If yes, please explain_____

Describe your child's sleeping patterns:_____

Describe your child's eating habits:_____

E. Residences

Homes

Dates From	To	Location	Reason for moving	With whom	Any problems?

Residential placements, institutional placements, or foster care (if applicable)

Dates From	To	Program name or location	Reason for placement	Problems?

F. Educational Experiences

School (Name, district, address, phone) Grade Age Teacher

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Please indicate if any of the following are applicable:

Failed any grades	Yes	No
Retained in grade	Yes	No
Skipped a grade	Yes	No
Took special classes	Yes	No
Evaluated by school	Yes	No
Labeled by school	Yes	No
Had learning difficulties	Yes	No
Received tutorial assistance	Yes	No
Suspended from school	Yes	No
Reading problems	Yes	No
Arithmetic problems	Yes	No
Writing problems	Yes	No
Performance was variable or unpredictable	Yes	No
Told that child was not achieving up to potential	Yes	No
Does the child dislike school	Yes	No

Did any other significant events occur during school?
If yes, please describe:_____
_____
_____

Describe the child's academic progress thus far:_____

G. Recreational

List hobbies, sports; recreational, TV, and toy preferences; etc.: _____
_____

Does the child have problems relating to or playing with other children?_____

Does the child fight frequently with playmates?_____

Does the child prefer playing with younger children?_____

Does the child have difficulty making friends?_____

Does the child prefer to play alone?_____

H. Extended Family History

Has any individual in the child's immediate or extended family ever been diagnosed with the following:

Learning Disabilities? If yes, please list who:_____

Anxiety? If yes, please list who:_____

Depression? If yes, please list who:_____

Manic-Depression? If yes, please list who:_____

Substance use or abuse? If yes, please list who:_____

Any other diagnosis? If yes, please list who:_____

I. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____
_____
_____
_____