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Child Developmental History Form

Date:___________________

CHILD NAME: ________________________________ DOB: __________________

Please take your time and complete entire form. The information will help me understand your child and your family better. Use the back of the sheet if necessary.

FAMILY BACKGROUND

Full Name	**Year of birth**	**Current medical condition(s)**	**If Deceased, year/cause**
Mother			
Father			
Other Parental Figure(s)			
Siblings			
Stepsiblings			

Pets

Name	When adopted?	Type of Animal

Who lives in your home now? ____

Child raised by: ____

Family members child is close to: ____

Extended family members nearby: ____

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Parents' Marital Status:

Unmarried ___________		
Live together _________	How many years? ___________________	
Married _____________	How many years? ___________________	
Separated ____________	How many years? ___________________	
Divorced ____________	How many years? ___________________	
Widowed ____________	How many years? ___________________	

	Mother	**Father**	**Other parental figure**
Education/highest grade completed			
Ethnic background			
Hobbies and interests			
Occupation			
Full-time/Part-time			
Religion			

ADOPTION HISTORY

At what age was your child adopted? ____

From where was your child adopted? ____

Does your child know she's adopted? ____

Is there contact with biological family? ____

Are there concerns about the adoption? ____

PREGANCY HISTORY

Age of biological parents at time of birth: Mother:_________ Father:___________

Was this a planned pregnancy? ________________

Were there fertility complications? _________

Please describe____

Did the birth mother receive prenatal care? Yes_____ No_____

Please describe: ____

Length of pregnancy: __________________

Did the mother experience any emotional or physical difficulties during or after the pregnancy? ___

Please describe: ____

Length of labor: _________

Birth weight: _____________

Was it a Caesarian delivery? ____________Was delivery scheduled or unscheduled?___________

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DEVELOPMENTAL HISTORY

Was this child breast-fed or bottle-fed? ____________________________ Age weaned: _______

Did the child experience any of the following:

	Infancy	Toddler	Preschool	Now
Colic				
Excessive crying				
Delayed language				
Unclear speech				
Eating/feeding problems				
Delayed fine motor skills				
Delayed gross motor skills				
Other:				

Please give the age when your child reached each developmental milestone:

Crawling: _______________ Sitting:________________ Walking:______________________

First words: ____

First sentences:____

Toilet trained:_______________

For an adolescent, please indicate the following:

Age at onset of puberty: ______ Age at first menstruation: __________

Which hand/foot does your child use for writing? _______ eating? _______
throwing? __________ kicking? __________

At what did your child learn to ride a bicycle (no training wheels!): _________

MEDICAL BACKGROUND

Pediatrician: ____
Address: ____

____
Phone: ______________________________ FAX: _____________________________
Email: ____

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Date of last physical exam: ______________________ Results: ___________________
Date of last dental exam: ________________________ Results: ___________________
Date of last vision exam: ________________________ Results: ___________________
Date of most recent hearing exam: _______________ Results: ___________________

Has this child experienced any of the following (check all that apply):

Allergies
Asthma
Cerebral palsy
Congenital problems
Frequent colds
Frequent ear infections
Gastrointestinal problems
Hearing problem
Lead poisoning
Muscle pain
Repetitive behaviors (rocking, head banging, etc.)
Seizures
Skin problems
Vision problems
Other: _______________________

Please describe any items checked above: ____
____

Is this child on any medications? Please list below

Medication	**Dosage**	**Frequency**	**Prescriber**	**Date Prescribed**	**Still Used?**	**Reason Prescribed**

Does this child use alcohol or drugs? ______ If yes, please list: ____________________________

____

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PREVIOUS ASSESSMENTS

Type of assessment	Date	Name of clinician	Reason for evaluation	Results
Neurological				
Neuropsychological				
Occupational therapy				
Physical therapy				
Psychiatric				
Psychological				
Speech & language				

(continue on back if necessary)

Please provide copies of all reports.

MENTAL HEALTH TREATMENT HISTORY

Has your child ever received counseling or psychiatric treatment? _____________

Type of treatment	Dates	Clinician	Reason	Was it helpful? (please explain)

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MENTAL HEALTH HISTORY

Please check all that apply

Condition	This child	Family member (indicate which)
Anxiety		
Agoraphobia		
Generalized anxiety disorder		
Obsessive compulsive disorder		
Panic disorder		
Post traumatic stress disorder		
Specific phobia		
Social phobia		
Mood		
Bipolar disorder		
Dysthymia		
Major depression		
Psychotic symptoms		
Abuse/trauma		
ADD/ADHD		
Adjustment disorder		
Alcohol or substance abuse		
Eating disorder		
Schizophrenia		
Self-harming behavior		
Suicide	N/A	
Suicidal behavior or statements		
Other:		

SOCIAL HISTORY

Did/does your child have any difficulties with daycare, preschool or school? Please explain:
____
____

Does your child have friends? __________ Has your child ever been bullied? ___________

What interests does your child have? ____
____

What are your family's favorite activities? ______________________________________
____

Does this child enjoy participating in those? _____________________________________

Client Name: ________________________________

EDUCATIONAL HISTORY

Name of schools attended and location:

Preschool: ____
Elementary School: ____
Middle School: ____
High School: ____

Did/does your child have any problem with the following areas?

Listening
Completing work
Doing homework independently
Paying attention
Unstructured time
History/Social Studies
Math
Reading
Science
Writing

Was your child ever referred for an IEP or 504 evaluation at school? ______________________
Is your child currently on an IEP or 504?____

Does your child receive in-school services or tutoring?

Subject/Service	School/Home	Frequency	Does your child like it?	Does it help?

Are you satisfied with your child's current educational placement? (Please explain.)

____

Does your child like going to school? ____

What is your child's approach to schoolwork (organized/disorganized, responsible, attentive, uninterested): ____

Client Name: ________________________________

WORK HISTORY

Does your child have a job? ____________

Where does your child work? __________________ How many hours/week? ________________

What does your child do? ____

Is your child successful at this job? ____

REASONS FOR SEEKING COUNSELING

Why have you decided to seek therapy?

____

____

What type of therapy are you interested in for your child?

Individual
Family
Anxiety management
Cognitive/behavorial
Social skills
Stress management
Trauma

What are your goals for therapy?

____

____

What are your biggest concerns about your child? ____

Is there anything else that you think it is important for me to know?

____

____