CHILDHOOD DEVELOPMENTAL HISTORY

Person Completing Form ____________________Relationship to Child ____________________Date_____

Child's Name______________________Birthdate____________________Age______________________

Home Address____
(Street) (City/Town) (State) (Zipcode)

Home Telephone___________________ Child's School________________________ Grade___________

Special School Placement or Services(if any)____

Adults living with Child____
(name and relationship)

Siblings (name and age)____

PARENTS

Father________________________ Occupation_____________________ Work Telephone____________

Mother_______________________ Occupation_____________________ Work Telephone____________

Pregnancy Complications

Vomiting____ Staining or blood loss______ Infections____ Toxemia____ Threatened Miscarriage___
Other Illness____
Smoking During Pregnancy____Number of cigarettes per day ________ Drug or alcohol use___________
Duration of Pregnancy (weeks)______________Other Complications______________________________

DELIVERY

Type of labor: Spontaneous____ Induced____ Duration (hours) ____ Birth Weight _______
Type of Delivery: Normal ____ Breech ____ Cesarean ____
Complications: Cord around neck ____ Hemorrhage__ Infant Injury ____

POST DELIVERY: Jaundice ____ Cyanosis (blue baby) ____ Incubator Care____ Infection _______
(specify)

INFANCY:

Difficult to calm or comfort ______ Colicky _____ Excessively irritable_____ Head Banging_____
Difficulty nursing____ Disturbed sleep patterns (describe)_____________________________________
Other:____

MEDICAL HISTORY:

Childhood Diseases (describe ages and complications)____

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Hospitalizations____
Head Injury_____ Coma_______ Convulsions with fever ______ without fever_________________
Eye problems (specify)_________________________ Ear problems (specify) _____________________
Allergies (specify)____ Asthma _____________
Eating Problems____
Sleep Disorders____
Other Problems____

MENTAL HEALTH HISTORY

Describe any past history of severe social, emotional or behavioral problems_______________________

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Patient Name:_______________________________________ Date:______________________________

Describe any significant history of physical or emotional trauma____________________________________

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List previously seen mental health providers and addresses if available______________________________

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PRESENT MEDICAL STATUS

Present illnesses for which the child is being treated____
Prescription Medications____
Name of Primary Care or other treating physicians____
Date of last medical checkup ____

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you do not recall the age, check the categories to the right.

	AGE	EARLY	NORMAL	LATE
Sat without support				
Crawled				
Walked without assistance				
Spoke first words				
Said sentences				
Toilet Trained				

FAMILY HISTORY

For each of the following, please specify which relative (parents, siblings, grandparents, aunts, uncles or cousins) and which side of the family (maternal or paternal) has or had a history of the problem or disorder.

Reading Disorder_________________________________
Math Disorder____________________________________
Speech Impairment________________________________
Mental Retardation________________________________
Epilepsy____
Tic Disorder______________________________________
Tourette's Syndrome_______________________________
Behavior Problems________________________________
(Childhood)

Thyroid Disorder_____________________________
Genetic Disorder_____________________________
(Specify)
Depression__________________________________
Bipolar Disorder_____________________________
Obsessive-Compulsice Disorder_______________
Social Phobia________________________________
Panic Disorder_______________________________
Attention/Hyperactivity Disorder_______________

SCHOOL EXPERIENCE

Rate your child with regard to academic performance

GRADE	GOOD	AVERAGE	POOR
Kindergarten			
Earlier Grades			
Current Grade			

What is your child's grade level in: Reading_____ Spelling_____ Math_____
Has your child ever had to repeat a grade?___________ If so, what grade_________________________
Has your child ever been evaluated for Special Education?____________ If so, for what reason_________

Has he/she been identified and received services?____

Patient Name:_______________________________________ Date:______________________________

BEHAVIOR CHECKLIST

Please check all of the following that apply to your child:

Is moody	Has a bad temper	Cries easily
Is a worrier	Has bad dreams	Is often sad
Is often quiet	Is fearful of new situations	Is fearful of being alone
Is often tired	Stutters or stammers	Frequent stomach aches
Frequent headaches	Wets bed or pants often	Soils or has bowel accidents
Frequent diarrhea	Frequent constipation	Overeats
Bites nails	Is slow to trust	Demands to be the center of attention
Fights with siblings	Excessively neat or orderly	Too concerned about germs or cleanliness
Tells lies	Steals	Plays with fire
Bullies other children	Is fresh or rude to adults	Is mean
Destroys own property	Destroys others property	Deliberately provokes adults
Frequently in trouble with neighbors	Is cruel to animals	Is a loner
Has no real friends	Has mostly younger friends	Has mostly older friends
Is bossed by other children	Prefers to play alone	Gets picked on
Is not liked by other children	Difficulty sustaining attention	Makes careless mistakes
Often does not seem to listen	Fails to finish things	Difficulty organizing activities
Avoids sustained mental effort	Often loses things	Easily distracted
Forgetful in daily activities	Often fidgets	Often out of his/her seat in the classroom
Is hyperactive	Difficulty playing quietly	Talks excessively
Blurts out answers before questions are completed	Difficulty waiting turn	Often interrupts or intrudes
IF YOUR CHILD IS 12 YEARS OR OLDER		
Is sexually active	Appears confused about gender	Displays interest in the same sex
Behavior is rigid and repetitive	Is troubled by obsessive thoughts	Has many health complaints
Experiences times of extreme fear or panic	Uses alcohol	Uses illegal drugs
Inhales household chemicals		

Additional Remarks: (use other side of paper if more space is required)