

## 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) \_\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_\_\_ Thyroid Disorder \_\_\_\_\_

Math Disorder \_\_\_\_\_ Genetic Disorder \_\_\_\_\_

(Specify)

Speech Impairment \_\_\_\_\_ Depression \_\_\_\_\_

Mental Retardation \_\_\_\_\_ Bipolar Disorder \_\_\_\_\_

Epilepsy \_\_\_\_\_ Obsessive-Compulsive Disorder \_\_\_\_\_

Tic Disorder \_\_\_\_\_ Social Phobia \_\_\_\_\_

Tourette's Syndrome \_\_\_\_\_ Panic Disorder \_\_\_\_\_

Behavior Problems \_\_\_\_\_ Attention/Hyperactivity Disorder \_\_\_\_\_

(Childhood)

**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
<b>IF YOUR CHILD IS 12 YEARS OR OLDER</b>		
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)