

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 _____

List previously seen mental health providers and addresses if available _____

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
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)