

Client Name: _____

Child/Adolescent Developmental History Form

GENERAL INFORMATION

Child's full name _____ Grade _____ Age _____ DOB _____

Current Address: _____ How long at this address _____

Person providing this information: _____ Relationship to child _____

Who does child live with: ☐ both parents ☐ mother ☐ father ☐ other (specify) _____

Biological father _____ Occupation _____ Years education: _____

Father's home phone _____ Work phone _____ Cell Phone _____

Biological mother _____ Occupation _____ Years education: _____

Mother's home phone _____ Work phone _____ Cell Phone _____

☐ N/A Guardian's name _____ Occupation _____ Years education: _____

Guardian's home phone _____ Work phone _____ CellPhone _____

Please list all people in child's immediate family:

Name	Relationship to child	Age/ Grade	Living in house?

Please list all other *non-family* members who live in household:

Name	Relationship to child/family	How long living in household?

Language(s) spoken at home _____ Primary Language at home _____

Please List all locations (city, state) that your child has lived:

1. Birthplace _____ Moved at age/grade _____

2. _____ Moved at age/grade _____

3. _____ Moved at age/ grade _____

Client Name: _____

Are biological parents of child currently: ☐ married ☐ separated ☐ divorced ☐ never married

- If separated or divorced, who has *legal* custody? ☐ mother ☐ father ☐ other (specify): _____
- If separated or divorced, how do you feel your child has adjusted to separation/divorce?

Are there other adults who have a *significant* part in raising your child? ☐ Yes ☐ No

If so, please indicate name & relationship (i.e. step-parent, grandparent, etc.) _____

Have there been any significant changes in the home over the last few years? (such as new marriages, deaths, births, address changes, family separation/divorce, parent dating, money problems, etc.)

What do you feel are your child's...

Strengths _____

Weaknesses _____

Briefly describe your concerns for your child.

HEALTH AND DEVELOPMENT

Is your child your: ☐ biological child ☐ adopted child ☐ foster child ☐ other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? ☐ Yes ☐ No

Please specify any medications used during pregnancy and the reason used: _____ Pregnancy lasted

_____ weeks/ months Child's birth weight: _____ pounds _____ ounces

Please check the conditions below that describe the health of the child and mother during...

Mother's Pregnancy

- ☐ No Complications
- ☐ Blackouts
- ☐ Falls
- ☐ Physical Injury
- ☐ Excessive Bleeding
- ☐ Hypertension
- ☐ Diabetes
- ☐ Emotional Stress
- ☐ Toxemia
- ☐ Alcohol/ Drug Use
- ☐ Use of Tobacco

Child's Delivery

- ☐ Normal
- ☐ Induced Labor
- ☐ C-Section
- ☐ Breech birth
- ☐ Unusually long labor (>12hrs)
- ☐ Premature # of weeks _____
- ☐ Overdue # of weeks _____
- ☐ Other Problem (Specify) _____

Child's Condition at Birth

- ☐ Normal/ No problems
- ☐ Lack of Oxygen
- ☐ Breathing Problems
- ☐ Birth Injury/ Defect
- ☐ Jaundice
- ☐ Newborn ICU # of day _____
- ☐ Other Problem (Specify) _____

Describe the state of your child's current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please list medication and uses: _____

Has your child ever been identified as having a disability? ☐ Yes ☐ No If so, by whom, what age, & what disability?

Has your child ever received psychological counseling? ☐ Yes ☐ No If yes, by whom (professional/ agency) and when:

Client Name: _____

Has your child had any of the following?	Please describe and give details, dates, and/or age onset
☐ Serious Injuries	
☐ Head Injuries	
☐ Surgery/ Hospitalization	
☐ Seizures or convulsions	
☐ Other health problem:	

Is there a family history of the following?	Biological family member with the history...
☐ Learning Difficulties (reading, math, writing)	
☐ Speech or Language problem (stuttering, etc.)	
☐ Developmental Disorder (such as Autism, etc.)	
☐ Emotional Problems (depression, mood swings, etc.)	
☐ Intellectual Disability	
☐ Academic Setbacks (failing grades, dropout, etc.)	
☐ Drug or Alcohol Addiction	

Please indicate the age or age range when your child performed the following milestones:

[illegible]

BEHAVIOR

During your child's first few years of life, were any of the following significantly present?

- | | |
|---|---|
| ☐ Difficult to comfort | ☐ Difficult nursing |
| ☐ Was not easily calmed by being held or stroked | ☐ Poor eye contact |
| ☐ Colicky | ☐ Did not respond to their name |
| ☐ Excessive irritability | ☐ Fascination with certain objects |
| ☐ Diminished sleep | ☐ Constantly head banging |

* If you checked any of the above, please describe _____

Child's Early Temperament: (Toddler through five years of age)

Activity Level- How active has your child been from an early age? _____

Distractibility- How well was your child able to maintain focus or concentrate on tasks? _____

Adaptability- How well was your child able to deal with transition, change, or when denied their own way? _____

Mood- What was your child's basic mood? Did they exhibit frequent mood changes? _____

Regularity- How predictable was your child's patterns of activity level, sleep, appetite, etc.? _____

Prior to age six, did your child have more difficulty than other children his/her age...

- | | |
|---|--|
| ☐ Sitting still at meal time | ☐ Staying focused on TV, movies, etc. |
| ☐ Paying attention when read to | ☐ Waiting for turn at play |
| ☐ Throwing/ catching a ball | ☐ Knowing left and right |
| ☐ Buttoning and zipping | ☐ Dressing self |
| ☐ Holding crayon or pencil | ☐ Tying shoe laces |
| ☐ Accidentally dropping/knocking things over | |

Please check below all behaviors or characteristics that fit your child over the past year:

- | | |
|--|--|
| ☐ Destructive behavior | ☐ time |
| ☐ Is affectionate with family & friends | ☐ Explosive temperament |
| ☐ Responds well to authority figures | ☐ Frequently complains about aches and pains |
| ☐ Boundless energy and poor judgement | ☐ Appears to have low self-esteem |
| ☐ Cruelty to animals | ☐ Prefers to be alone (or considers self "a loner") |
| ☐ Disorganized, loses things often | ☐ Lacks motivation |
| ☐ Shows sudden physical aggression | ☐ Steals or lies |
| ☐ Frustrated easily | ☐ Becomes upset with change |
| ☐ Shifts from one activity to another | ☐ Fearfulness |
| ☐ Has difficulty playing quietly | ☐ Frequent peer and/or family conflicts |
| ☐ Requires a lot of parent attention | ☐ Starts fires |
| ☐ Fidgets a lot | ☐ Does not appear to listen to what is being said |
| ☐ Appears to daydream or "zone out" often | ☐ Always worrying about something |
| ☐ Nervous habits (nail biting, hair twirling, etc.) | |
| ☐ Appears depressed & unhappy much of the | |

Client Name: _____

How often are each of the following settings a *problem* for your child?

Problems include: doesn't follow directions/rules, needs reminders, argues/fights, whines/cries, fidgets, etc.

- | | | | |
|---|---------------------------------|------------------------------------|-------------------------------------|
| • While getting ready for school... | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| • When playing by him/herself... | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| • When with a babysitter or at daycare... | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| • When in the car | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| • When watching TV or playing games... | ☐ Rarely | ☐ Sometimes | ☐ Frequently |

How would you describe your child's personality at home? _____

Which adult would your child prefer to talk with about a problem? _____

Who is the family member that your child feels closest to? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home?

How does your child respond to discipline? _____

List any responsibilities your child has at home: _____

* Does your child do these regularly? ☐ Yes ☐ No Does your child need frequent reminders? ☐ Yes ☐ No

Indicate your child's... Bed time? ____:____ Wake time? ____:____ Do they sleep well? _____

How much time does your child typically spend on electronic media?

Watching TV: ____ hrs./day Playing video/computer games: ____ hrs./day Other _____

Have any family members expressed concerns about your child's behavior? ☐ Yes ☐ No If yes, explain:

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc?) _____

EDUCATIONAL HISTORY

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? ☐ Not a struggle ☐ Sometimes a struggle ☐ Often a struggle

Does your child receive special school service? ☐ Yes ☐ No

If yes, which program and when services began _____

Below please list school attended and describe your child's academic and behavioral performance:

Preschool/ Daycare _____

Elementary School _____

Middle School _____

High School _____



Functional Analysis Screening Tool (FAST):

If you or your child engages in challenging behaviors (e.g., aggression, self-injury, property destruction, elopement, frequent tantrums, severe noncompliance, repetitive behaviors, or other behaviors that significantly interfere with daily functioning), please complete the FAST questionnaire.

This screening tool helps your therapist identify possible factors contributing to these behaviors and supports the development of an individualized treatment plan. For child clients, this form should be completed by a parent, legal guardian, or caregiver who regularly observes the child's behavior.



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Functional Behavior Screening

Functional Assessment Screening Tool (FAST)

Designed to help identify the why behind your child's challenging behaviors

What is the FAST?

The Functional Assessment Screening Tool (FAST) is a brief screening form used to help identify what might be causing or maintaining a child's problem behavior. It is part of a larger process called a Functional Behavior Assessment (FBA).

By answering this questionnaire, you're helping your child's therapist better understand:

- When and why certain behaviors occur.
- What your child might be trying to get or avoid through their behavior (called the function of behavior).
- What supports or interventions may help reduce the problem behavior.

This form is designed to be simple, parent-friendly, and easy to complete.

What Does Each Section Measure?

Section	Focus	What It Measures
Part 1	Social Triggers	Whether other people or interactions are related to the behavior
Part 2	Social Reinforcement	Whether behaviors are maintained by attention, getting things, or avoiding tasks
Part 3	Automatic Reinforcement	Whether behaviors serve internal (sensory or pain) needs, not related to others

Client Name: _____

Behavior Screening Form

Child's Name: _____ Age: _____ Date: _____

Person Completing This Form: _____

☐ Parent ☐ Guardian ☐ Other: _____

Do you spend time with the child daily? ☐ Yes ☐ No

If yes, how many hours/day? _____ If no, hours/week? _____

Where do you typically observe the behaviors? (Check all that apply)

☐ At home ☐ Schoolwork ☐ Playtime ☐ Transition times

☐ When told "no" ☐ When alone ☐ Other: _____

Part 1: Social Triggers

- ☐ Yes ☐ No - The behavior happens when others are around.
- ☐ Yes ☐ No - It happens soon after someone talks to your child, gives a direction, or removes something.
- ☐ Yes ☐ No - When it happens, your child shows big emotions (e.g., crying, yelling).

Part 2: Possible Reasons – Social Reinforcement

- ☐ Yes ☐ No - Behavior happens more when your child hasn't gotten attention.
- ☐ Yes ☐ No - People usually respond with correction, comfort, or redirection.
- ☐ Yes ☐ No - Your child often acts in ways to get attention.
- ☐ Yes ☐ No - Your child often seeks out social interaction.
- ☐ Yes ☐ No - The behavior is rare when your child is receiving attention.
- ☐ Yes ☐ No - Behavior occurs when your child can't have something they want.
- ☐ Yes ☐ No - Behavior occurs when a fun activity ends.

Client Name: _____

- ☐ Yes ☐ No - You sometimes give a toy/snack to calm your child down.
- ☐ Yes ☐ No - Your child often acts out to get something they want.
- ☐ Yes ☐ No - Behavior rarely happens during tasks or learning.
- ☐ Yes ☐ No - Behavior happens more during tasks or chores.
- ☐ Yes ☐ No - Your child often avoids or resists demands.
- ☐ Yes ☐ No - Behavior happens more in loud or crowded settings.
- ☐ Yes ☐ No - You sometimes give a break when behavior happens.
- ☐ Yes ☐ No - Behavior is rare when no demands are placed.

Part 3: Possible Reasons – Automatic Reinforcement

- ☐ Yes ☐ No - Behavior happens more when your child is alone or bored.
- ☐ Yes ☐ No - It happens regardless of what's going on.
- ☐ Yes ☐ No - Your child rarely engages with toys or objects.
- ☐ Yes ☐ No - Your child doesn't respond much to social interaction.
- ☐ Yes ☐ No - Your child engages in repetitive actions (e.g., flapping, rocking).
- ☐ Yes ☐ No - People usually do nothing when this behavior happens.
- ☐ Yes ☐ No - The behavior goes through "cycles" — some days more than others.
- ☐ Yes ☐ No - The behavior increases when your child is sick.
- ☐ Yes ☐ No - Your child has frequent health issues (e.g., infections, skin conditions).

SCORING GUIDE (for clinician use)

Circle all items answered "Yes" and refer to this table:

Function of Behavior	If 'Yes' to any of these items...
Attention	1, 2, 3, 4, 5, 6, 7, 8
Access to Items/Activities	1, 2, 3, 9, 10, 11, 12, 13
Escape/Avoidance	1, 2, 3, 14, 15, 16, 17, 18
Sensory Stimulation (Automatic)	19, 20, 21, 22, 23, 24
Pain Attenuation (Automatic)	19, 20, 24, 25, 26, 27

The function with the most “Yes” responses may be the primary reason for the behavior.
This should be confirmed by observation and clinical review.

Additional Notes (Optional):