**Child/Adolescent Developmental History Form**

**GENERAL INFORMATION**

Child’s full name  Grade AgeDOB 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  Year’s education:  Father’s home phone  Work phone  Cell Phone

Biological mother  Occupation  Year’s education Mother’s home phone  Work phone  Cell Phone

**[ ]**  N/A Guardian’s name Occupation Year’s 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

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 week

**[ ]**  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:

|  |  |
| --- | --- |
| 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.) |  |
| **[ ]**  Mental Retardation |  |
| **[ ]**  School Failure (failing grades, dropout, etc.) |  |
| **[ ]**  Drug or Alcohol Addiction |  |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Milestone: | 0-3 months | 4-6 months | 7-12 months | 13-18 months | 19-24 months | 2-3 years | 3-4 years |
| Sat upwithout help | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Crawled | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Walked | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Spoke firstWords | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Spokesentences | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Fully pottyTrained | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Stayed dryall night | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

**BEHAVIOR**

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

**[ ]**  Difficult to comfort

**[ ]**  Was not easily calmed by being held or

stroked

**[ ]**  Colicky

**[ ]**  Excessive irritability

**[ ]**  Diminished sleep

**[ ]**  Difficult nursing

**[ ]**  Poor eye contact

**[ ]**  Did not respond to their name

**[ ]**  Fascination with certain objects

**[ ]**  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

**[ ]**  Paying attention when read to

**[ ]**  Throwing/ catching a ball

**[ ]**  Buttoning and zipping

**[ ]**  Holding crayon or pencil

**[ ]**  Accidently dropping/knocking things over **[ ]**  Staying focused on TV, movies,etc.

**[ ]**  Waiting for turn at play

**[ ]**  Knowing left and right

**[ ]**  Dressing self

**[ ]**  Tying shoe laces

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

**[ ]**  Destructive behavior

**[ ]**  Is affectionate with family & friends

**[ ]**  Responds well to authority figures

**[ ]**  Boundless energy and poor judgement**[ ]**  Cruelty to animals

**[ ]**  Disorganized, loses things often

**[ ]**  Shows sudden physical aggression

**[ ]**  Frustrated easily

**[ ]**  Shifts from one activity to another

**[ ]**  Has difficulty playing quietly

**[ ]**  Requires a lot of parent attention

**[ ]**  Fidgets a lot

**[ ]**  Appears to daydream or “zone out” **[ ]** Nervous habits nail biting, hair twirling,

**[ ]**  Appears depressed & unhappy much of the time

**[ ]**  Explosive temperament

**[ ]**  Frequently complains about aches and pains

**[ ]**  Appears to have low self-esteem

**[ ]**  Prefers to be alone (or considers self “a loner”)

**[ ]**  Lacks motivation

**[ ]**  Steals or lies

**[ ]**  Becomes upset with change

**[ ]**  Fearfulnes

**[ ]**  Frequent peer and/or family conflicts **[ ]**  Starts fires

**[ ]**  Does not appear to listen to what is being said

**[ ]** Always worrying about something

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…

• When playing by him/herself…

• When with a babysitter or at daycare…

• When in the car…

• When watching TV or playing games…

**[ ]** Rarely

**[ ]** Rarely

**[ ]** Rarely

**[ ]** Rarely

**[ ]** Rarely

**[ ]** Sometimes

**[ ]** Sometimes

**[ ]** Sometimes

**[ ]** Sometimes

**[ ]** Sometimes

**[ ]** Frequently

**[ ]** Frequently

**[ ]** Frequently

**[ ]** Frequently

**[ ]** 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