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# CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

***Directions:*** *To the best of your ability, please answer all of the questions.*

**Form completed by:** _____

**Relationship to child** _____ **Date:** _____

Child's Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____

Grade (if applicable): _____ School/Preschool: _____

Primary language spoken by the child: _____

Primary language spoken at home: _____

Insurance: ☐ No ☐ Yes _____

***FAMILY INFORMATION***

With whom does the child live (check all that apply):

☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Foster Parent ☐ Aunt ☐ Uncle ☐ Siblings

☐ Other (please list): _____

If parents are divorced, separated, or not with the child, who has custody? _____
If child is not living with a parent, does s/he see this parent ☐ Yes ☐ No
If so, how often? _____

| **Mother's Name:** | **Father's Name:** |
|---|---|
| Occupation: | Occupation: |
| Employer: | Employer: |
| Ethnicity: | Ethnicity: |
| Highest Grade Completed: | Highest Grade Completed: |

**Please list all persons residing with the family and their relationship to the child.**

| Name | Age | Gender | Relationship to child |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***PREGNANCY and BIRTH***

At the time of this child's birth, what was the mother's age?_____ Father's age_____

Did mother receive prenatal care? ☐None ☐ Yes - throughout entire pregnancy

☐ Some _____

**Check any of the following complications that occurred during the pregnancy:**

☐Measles ☐German Measles ☐Excessive Swelling ☐Anemia ☐Toxemia ☐Vaginal Bleeding ☐Flu

☐Rh Incompatibility ☐Abnormal weight gain ☐High Blood Pressure ☐Excessive Vomiting

☐Emotional Problems _____

☐ Stressors (describe) _____

☐ Other not listed: _____

| **Pregnancy Cont.** | | | **If yes…** |
|---|---|---|---|
| **Injury to Mother:** | ☐ Yes | ☐ No | Describe:_____ |
| **Hospitalization during pregnancy** | ☐ Yes | ☐ No | Reason:_____ |
| **X-ray during pregnancy:** | ☐ Yes | ☐ No | What month:_____ |
| **Medications used during pregnancy:** | ☐ Yes | ☐ No | Name:_____ |
| **Alcohol or other drugs used prior to discovering pregnancy** | ☐ Yes | ☐ No | When was pregnancy discovered? _____ |
| **Alcohol used during pregnancy:** | ☐ Yes | ☐ No | Frequency:_____ |
| **Cigarettes used during pregnancy:** | ☐ Yes | ☐ No | Frequency:_____ |
| **Other drugs used during pregnancy:** | ☐ Yes | ☐ No | Type and frequency:_____ |

**Length of pregnancy:**_____ **Length of labor:**_____

**Length of stay in hospital?** Mother:_____ Child:_____

**Birth weight:** _____lbs _____oz **Apgar Score(s)** _____

**Child's condition at birth:**_____

**Mother's condition at birth:**_____

**Check any of the following complications that occurred during or after birth:**

- ☐ Forceps used
- ☐ Labor induced
- ☐ Infection
- ☐ Cord wrapped around neck
- ☐ Need supplemental oxygen
- ☐ Incubator
- ☐ Breech birth
- ☐ Caesarean delivery
- ☐ Seizures
- ☐ Jaundice
- ☐ Ventilator
- ☐ Problems with heart
- ☐ Problems with bones
- ☐ Blood transfusion
- ☐ Cyanosis
- ☐ NICU stay

☐ Other:

_____

***DEVELOPMENTAL INFORMATION***

**Please indicate/estimate the age at which your child achieved the following milestones.**

_____Turned over

_____Sat alone

_____Crawled

_____Stood alone

_____Walked alone

_____Walked up stairs

_____Walked down stairs

_____Showed an interest in/attraction to sound

_____Understood first words

_____Spoke first words

_____Toilet trained during the day

_____Toilet trained at night

**Does your child continue to have toileting accidents?** ☐**Yes** ☐**No**
**If so, where does this happen?:**_____ **How Often:**_____

**Were/are there any medical reasons for the toileting accidents?**_____

**Has your child experienced any of the following problems? If so please describe:**

☐ Walking difficulty _____

☐ Unclear speech _____

☐ Feeding/ eating difficulties _____

☐ Underweight _____

☐ Overweight _____

☐ Difficulty learning to skip _____

☐ Difficulty learning to throw or catch _____

☐ Difficulty learning to ride a bike _____

**During the first 4 years, were any of the following problems noted? If so, please describe:**

☐ Eating _____

☐ Motor skills _____

☐ Sleeping too much _____

☐ Sleeping too little _____

☐ Temper tantrums _____

☐ Failure to thrive _____

☐ Separating from parents _____

☐ Excessive crying _____

**Is your child?** ☐**right handed** ☐**left handed** ☐**both** ☐**undecided**

**Has your child lost any skills (e.g., use to say sentences but has now stopped)?**

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***MEDICAL INFORMATION***

**Please check any of the following that your child has had, and indicate the age?**

| | Age | | Age |
|---|---|---|---|
| ☐ Measles | _____ | ☐ German Measles | _____ |
| ☐ Mumps | _____ | ☐ Rheumatic Fever | _____ |
| ☐ Chicken Pox | _____ | ☐ Diphtheria | _____ |
| ☐ Tuberculosis | _____ | ☐ Meningitis | _____ |
| ☐ Whooping Cough | _____ | ☐ Encephalitis | _____ |
| ☐ Anemia | _____ | ☐ Seizures | _____ |
| ☐ Diabetes | _____ | ☐ Asthma | _____ |
| ☐ Rashes | _____ | ☐ Hay fever | _____ |
| ☐ Eczema | _____ | ☐ Seasonal allergies | _____ |
| ☐ Broken Bones | _____ | ☐ Pneumonia | _____ |
| ☐ Food allergies | _____ | ☐ Frequent headaches | _____ |
| ☐ Stomach aches | _____ | ☐ Other | _____ |

| **Hearing:** | | | **Vision:** | | |
|---|---|---|---|---|---|
| Frequent ear infections | ☐ Yes | ☐ No | Vision problems | ☐ Yes | ☐ No |
| Tubes | ☐ Yes | ☐ No | Wears Glasses | ☐ Yes | ☐ No |
| Hearing problems | ☐ Yes | ☐ No | | | |
| Sensitive to certain sounds | ☐ Yes | ☐ No | Sensitive to certain lights or colors | ☐ Yes | ☐ No |
| Has your child's hearing been evaluated? | ☐ Yes | ☐ No | Has your child's vision been evaluated? | ☐ Yes | ☐ No |

Hearing Evaluation Results : _____ Date: _____
Who tested hearing? (e.g., doctor, school, ECI) _____
Vision Evaluation Results: _____ Date: _____
Who tested vision? (e.g., doctor, school, ECI) _____

**Sleep**

| **Past** | **Present** | |
|---|---|---|
| ☐ | ☐ | No sleep difficulties |
| ☐ | ☐ | Trouble falling asleep |
| ☐ | ☐ | Wakes up frequently at night |
| ☐ | ☐ | Still tired after a good night's sleep |
| ☐ | ☐ | Does not get enough sleep |
| ☐ | ☐ | Restless in bed |
| ☐ | ☐ | Nightmares |
| ☐ | ☐ | Night terrors |
| ☐ | ☐ | Refuses to go to bed |
| ☐ | ☐ | Change in sleep pattern |
| ☐ | ☐ | Sleeps too much |
| ☐ | ☐ | Wakes up too early |
| ☐ | ☐ | Falls asleep in school |
| ☐ | ☐ | Refuses to get up in the morning |
| ☐ | ☐ | Snores |
| ☐ | ☐ | Sleeps with parent or sibling |
| ☐ | ☐ | Sleep Apnea (appears to hold breath when asleep) |

**Appetite**

| **Past** | **Present** | |
|---|---|---|
| ☐ | ☐ | Normal increase in weight/height |
| ☐ | ☐ | Unusual weight gain _____lbs. |
| ☐ | ☐ | Unusual weight loss _____lbs. |
| ☐ | ☐ | Concerns about height/growth? |
| ☐ | ☐ | Increase in appetite |
| ☐ | ☐ | Decrease in appetite |
| ☐ | ☐ | Gags on certain textures |
| ☐ | ☐ | Purposely throws up after eating |
| ☐ | ☐ | Food allergies _____ |
| ☐ | ☐ | Eats excessively |
| ☐ | ☐ | Picky eater |
| ☐ | ☐ | Will only eat certain types of food._____ |
| ☐ | ☐ | On a special diet_____ |

**Please indicate if your child has ever had any of the following? If so describe.**

- ☐ Seizure disorder _____
- ☐ Accident prone _____
- ☐ Bites nails or cuticles _____
- ☐ Sucks thumb _____
- ☐ Grinds teeth _____
- ☐ Has tics or twitches _____
- ☐ Bangs head _____
- ☐ Rocks back and forth _____
- ☐ Fever over 104 degrees _____
- ☐ Head injury _____
- ☐ Loss of consciousness _____

**Current medications, indicate dosage:**

_____ _____
_____ _____

**Previous medications (Indicate when s/he stopped taking them):**

_____ _____
_____ _____

**Primary care physician:**_____

**Has your child ever had psychological or psychiatric exam?** ☐ **Yes** ☐ **No**

Provider's name: _____
When: _____
Reason: _____

**Has your child ever had psychological counseling or therapy?** ☐ **Yes** ☐ **No**

Therapist's name: _____
When: _____
Reason: _____

**Has your child ever had a neurological exam?** ☐ **Yes** ☐ **No**

Neurologist's name: _____
When: _____
Reason: _____

**Describe any hospitalizations and/or surgeries and the dates:** _____
_____

**Please indicate if any <u>family members</u> have had the following and specify that person's relationship to the child.**

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Migraine headaches _____
- ☐ Physical handicap _____
- ☐ Tuberculosis _____
- ☐ Huntington's chorea _____
- ☐ Muscular dystrophy _____
- ☐ Sickle cell anemia _____
- ☐ Tay-sachs disease _____
- ☐ Tourette's syndrome _____
- ☐ Cerebral palsy _____
- ☐ Birth defect _____
- ☐ Alcohol abuse _____
- ☐ Drug abuse _____
- ☐ Behavior disorder _____
- ☐ Emotional problems _____
- ☐ Mental illness _____
- ☐ Mental retardation _____
- ☐ Nervousness _____
- ☐ Reading problems _____
- ☐ Learning disability _____
- ☐ Speech problem _____
- ☐ Language problem _____
- ☐ Severe head injury _____
- ☐ Other _____

**TEMPERAMENT, BEHAVIOR, AND RELATIONSHIPS:**

**Which describe your child's temperament before the age of two?**

- ☐ Calm
- ☐ Alert
- ☐ Affectionate
- ☐ Angry
- ☐ Active
- ☐ Unhappy
- ☐ Crying
- ☐ Fearful
- ☐ Sociable
- ☐ Happy
- ☐ Difficult
- ☐ Cranky
- ☐ Withdrawn
- ☐ Tired
- ☐ Irritable
- ☐ Playful
- ☐ Other_____

**Which describe your child now?**

- ☐ Calm
- ☐ Tired
- ☐ Affectionate
- ☐ Withholds affection
- ☐ Tearful
- ☐ Self-conscious
- ☐ Even tempered
- ☐ Lacks self control
- ☐ Active
- ☐ Cries a lot
- ☐ Difficult
- ☐ Happy
- ☐ Overreacts
- ☐ Gets mad easily
- ☐ Hides Feelings
- ☐ Difficult to calm
- ☐ Sociable
- ☐ Irritable/Cranky
- ☐ Distracted
- ☐ Sad
- ☐ Moody
- ☐ Easily upset by changes in routine
- ☐ Easily overstimulated
- ☐ Other _____
- ☐ Withdrawn
- ☐ Playful
- ☐ Funny
- ☐ Impulsive
- ☐ Worries

**What makes your child angry?**_____

**Does your child have any specific fears?** ☐ **Yes** ☐ **No**

Describe:_____

**Does your child engage in any ritualistic or compulsive behavior?** ☐ **Yes** ☐ **No**

Describe:_____

**Who is mainly in charge of discipline at home?**_____

**Do all caregivers agree on discipline?**_____

**Which of the following methods of discipline are used at home?**

- ☐ Verbal Reprimands
- ☐ Rewards
- ☐ Ignore behavior
- ☐ Time out
- ☐ Physical punishment
- ☐ Discuss behavior
- ☐ Loss of privileges
- ☐ Give in to child
- ☐ Earn privileges
- ☐ Other _____

**What discipline techniques are effective?**_____

**What discipline techniques are ineffective?**_____

**Has your child engaged in any of the following behaviors?**

- ☐ None
- ☐ Stolen without confrontation
- ☐ Lies often
- ☐ Hits other children
- ☐ Destruction of property
- ☐ Used/tried to use a weapon in a fight
- ☐ Stolen with confrontation
- ☐ Tries to Run away
- ☐ Deliberate fire-setting
- ☐ Hits adults
- ☐ Cruel to animals
- ☐ Often initiates physical fights

**How does your child relate to others?** Check all that apply

- ☐ Has many close friends
- ☐ Has several close friends
- ☐ Has few close friends
- ☐ Has no close friends
- ☐ Makes friends easily
- ☐ A leader
- ☐ A follower
- ☐ Fights with playmates
- ☐ Prefers to play alone
- ☐ Prefers younger children
- ☐ Prefers older children
- ☐ Prefers adults
- ☐ Interacts well with siblings
- ☐ Difficulty with siblings
- ☐ Teased by others
- ☐ Teases others
- ☐ Feels rejected by peer group
- ☐ Is jealous of others
- ☐ Has friends who get in trouble
- ☐ Wants friends, but doesn't know how to make or keep them

**Does your child ever say?** check all that apply

- ☐ I like my friends
- ☐ I like sitting with friends at lunch
- ☐ Kids hate me
- ☐ Kids are fun
- ☐ No one likes me
- ☐ Kids make fun of me
- ☐ I like my classmates
- ☐ I don't have any friends
- ☐ Kids pick on me
- ☐ I like recess
- ☐ I wish kids talked to me

**How does your child spend his/her free/play time?** _____
_____
_____

**Has your child experienced any of the following stressful events during the past year?** Check all that apply

- ☐ Parents separated or divorced
- ☐ Family accident or illness
- ☐ Death in the family
- ☐ Parent changed jobs
- ☐ Changed schools
- ☐ Family moved
- ☐ Family financial problems
- ☐ Chronic health problems
- ☐ Other:_____

**How many moves has your child had within the last three years?** _____

***ACADEMIC INFORMATION***

**List the schools your child has attended?** _____
_____

**Has your child been in a bi-lingual classroom?** ☐ No ☐ Yes. If yes – how long? _____

**Which of the following did your child attend?** Check all that apply

- ☐ Infant day care
- ☐ Kindergarten
- ☐ Preschool
- ☐ None

**Which of the following describe your child's kindergarten and first grade years?** Check all that apply

- ☐ Enjoyed school
- ☐ Felt neutral about school
- ☐ Afraid of school
- ☐ Complained of being sick to avoid school
- ☐ Always in trouble at school
- ☐ Disliked school
- ☐ Got along well with the teacher
- ☐ Got along poorly with the teacher
- ☐ Frequently absent
- ☐ Aggressive
- ☐ Active
- ☐ Distractible
- ☐ Disobedient
- ☐ Cooperative
- ☐ Liked to help the teacher
- ☐ Lost temper easily

**If applicable ,which of the following describe your child's experiences since the first grade?**
Check all that apply

- ☐ Good grades
- ☐ Frequently absent
- ☐ Failing grades
- ☐ Tested for special education
- ☐ Average grades
- ☐ Tested for the gifted program
- ☐ Cooperative student
- ☐ Tutored
- ☐ Suspended, _____number of times
- ☐ Retained, what year_____
- ☐ Expelled, _____number of times
- ☐ Loses temper easily

**What are your child's current subject strengths?**

| | | | |
|---|---|---|---|
| ☐ None | ☐ Math | ☐ History | ☐ Art |
| ☐ Spelling | ☐ Social Studies | ☐ English | ☐ Science |
| ☐ Music | ☐ Athletics/PE | ☐ Reading | ☐ Other |

**What are your child's current subject weaknesses?**

| | | | |
|---|---|---|---|
| ☐ None | ☐ Math | ☐ History | ☐ Art |
| ☐ Spelling | ☐ Social Studies | ☐ English | ☐ Science |
| ☐ Music | ☐ Athletics/PE | ☐ Reading | ☐ Other |

**Which are your child's current skill strengths?** Check all that apply

| | | |
|---|---|---|
| ☐ None | ☐ Getting assignments done | ☐ Intelligence |
| ☐ Concentration | ☐ Vocabulary/expression | ☐ Behaving correctly |
| ☐ Organization | ☐ Understanding concepts | ☐ Spelling |
| ☐ Memorization | ☐ Pleasing the teacher | ☐ Taking tests |
| ☐ Papers and reports | ☐ Reading speed | ☐ Turning in homework |
| ☐ Handwriting | ☐ Reading comprehension | ☐ Test preparation |
| ☐ Checking work carefully | ☐ Working hard | ☐ Other |
| ☐ Paying attention | ☐ Completing homework | |

**Which are your child's current skill weaknesses?** Check all that apply

| | | |
|---|---|---|
| ☐ None | ☐ Getting assignments done | ☐ Intelligence |
| ☐ Concentration | ☐ Vocabulary/expression | ☐ Behaving correctly |
| ☐ Organization | ☐ Understanding concepts | ☐ Spelling |
| ☐ Memorization | ☐ Pleasing the teacher | ☐ Taking tests |
| ☐ Papers and reports | ☐ Reading speed | ☐ Turning in homework |
| ☐ Handwriting | ☐ Reading comprehension | ☐ Test preparation |
| ☐ Checking work carefully | ☐ Working hard | ☐ Other |
| ☐ Paying attention | ☐ Completing homework | |

**What time does your child usually go to bed on school nights?**_____

***PRESENTING CONCERNS***

**In your opinion, what led to this referral** Check all that apply

- ☐ Developmental delays
- ☐ Symptoms of anxiety
- ☐ Thinking problems
- ☐ Adjustment to parents divorce
- ☐ Suspected abuse
- ☐ Suspected autism spectrum disorder
- ☐ Reading difficulties
- ☐ Behavior problems at home
- ☐ Symptoms of depression
- ☐ Suicidal thoughts
- ☐ Difficulties with parents
- ☐ Problems with peers/poor social skills
- ☐ Refusal to attend school
- ☐ Fears/Anxiety
- ☐ Academic difficulties
- ☐ Behavior problems at school

**How severe is/are the problem(s)?** _____

_____

_____

_____

**When were these problems first noted?**_____

_____

_____

_____

**What concerns you most about your child?** _____

_____

_____

_____

**What do you find most difficult about raising your child?**_____

_____

_____

_____

**What is the best thing about your child?**_____

_____

_____

_____

**Any additional information?**_____

_____

_____

_____