Child Developmental History Form

Today's date:_________________ Person(s) completing this form:____________________

A. Identification

Child's name:______________________________ Date of birth:_______________ Age:_______

Nicknames or aliases:________________________ Social Security #:_______________________

Child's Address: __________________________________City:_________________ Zip:_________

Parents are currently ◻ Married ◻ Divorced ◻ Remarried ◻ Never Married ◻ Other:____
____

Child's custodian/guardian is:____

Mother's name: __________________________________ Date of Birth:_____________________
Home phone:____________________________________ Cell phone:______________________
Address:________________________________City:________________________Zip:___________
Currently employed: ◻ NO ◻ YES, as:____
Work phone:_____________________________________E-mail:___________________________

Father's name: __________________________________ Date of Birth:______________________
Home phone:____________________________________ Cell phone:________________________
Address:________________________________City:________________________Zip:___________
Currently employed: ◻ NO ◻ YES, as:____
Work phone:_____________________________________ E-mail:___________________________

Stepparent's name: ______________________________ Date of Birth:_______________________
Home phone:____________________________________ Cell Phone: ________________________
Address: _______________________________ City:________________________Zip:___________
Currently employed: ◻ NO ◻ YES, as:____

Stepparent's name: ______________________________ Date of Birth:_______________________
Home phone:____________________________________ Cell Phone: ________________________
Address: _______________________________ City:________________________Zip:___________
Currently employed: ◻ NO ◻ YES, as:____

Calls or e-mail will be discreet, but please indicate any restrictions:_______________________
____

(cont.)

Please describe the reason(s) for today's visit:

____
____
____
____
____

Has your child ever received psychological, psychiatric, or counseling services before?
□ YES □ NO **If yes, please describe below:**

____
____
____

Past and current medications prescribed for treatments listed above:______________
____
____

B. Referral: Who gave you my name to call?

Name:_____________________________________ Phone:___________________________

Address:____

May I have your permission to thank this person for the referral? □ YES □ NO

C. Child's medical care: From whom or where do your child get medical care?

Clinic/doctor's name: _______________________________Phone:____________________

Address:____

____

Major Illnesses or Operations:____

____

____

Current Medications:____

____

How many hours of sleep does your child get per night?___________ Is this an adequate amount for him/her? □ YES □ NO Other sleep concerns:________________________

____

Any physical concerns:____

____

If your child enters treatment with me, may I tell his/her medical doctor so that he or she can be fully informed and we can coordinate your treatment? □ YES □ NO

(cont.)

B. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery
   Prenatal medical illnesses and health care:____
   ____
   ____

   Was the child premature? _________________ Weight and height at birth:_______________
   Any birth complications or problems?____
   ____

2. The first few months of life
   Breast-fed? _______________If so, for how long?___________________________________
   Any allergies?____

3. Sleep patterns or concerns:
____
____
____

4. Personality:
____
____
____

5. Milestones: At what age did this child do each of these?

Sat without support:_____________________ Crawled:_______________________________

Walked without holding on: _______________ Helped when being dressed:______________

Ate with a fork: _________________________Stayed dry all day:______________________

Didn’t soil his or her pants: _______________ Stayed dry all night:_____________________

Tied shoelaces:_________________________ Buttoned buttons:________________________

4. Speech/language development

Age when child said first word understandable to a stranger:___________________________

Age when child said first sentence understandable to a stranger:_______________________

Any speech, hearing, or language difficulties?_______________________________________

(cont.)

E. Child Education and Social History:

School:____Grade:________________________

Address: ____

Teacher's Name:______________________________Phone:_________________________

What Report Card Grades does your child usually receive:___________________________

____________________________________ Has this changed recently: ◻ YES ◻ NO

Does your child like school? Cooperate with homework?

____

____

____

Any social problems at school?

____

____

Any difficulties at home?

____

____

How are relationships with siblings?

____

____

What are your child's hobbies, interests, and strengths?

____

____

____

Briefly describe your child's friends:

____

____

____

Any concerns not mentioned:

____

____

____