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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_____ WorkTelephone_____

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_____
_____
_____
_____

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?_____

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: please use other side of this sheet