CHILDHOOD DEVELOPMENTAL HISTORY

Person Completing Form___________________Relationship to Child____________________Date

Child's Name_____________________DOB______________________Age_____________________

Home Address____
(Street) (City) (State) (Zip code)

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____________________Work Telephone___________

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_ _ _ _ _ _ _ _ _ _ _

Patient Name:-- **Date:**__________________________

Describe any significant history of physical or emotional trauma__________________________________

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List previously seen mental health providers and addresses if available_____________________________

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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________________________
Math Disorder___________________________
Speech Impairment
Mental Retardation
Epilepsy
Tic Disorder
Tourette's Syndrome
Behavior Problems_______________________________
(Childhood)

Thyroid Disorder_____________________________
Genetic Disorder____________________________
(Specify)
Depression_ _ _ _ _ _ _ _ _ _ _ _ _ _
Bipolar Disorder______________________________
Obsessive-Compulsive Disorder_______________
Social Phobia_ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Panic Disorder_ _ _ _ _ _ _ _ _ _ _ _ _
Attention/Hyperactivity Disorder_______________

SCHOOL EXPERIENCE
Rate your child with regard to academic performance:

GRADE	GOOD	AVERAGE	POOR
Kindergarten			
Earlier Grades			
Current Grade			

Patient Name:----------Date:_____

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 vour 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 younqer 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: (use other side of paper if more space is required)