Developmental History of Client if Currently a Child or Adolescent

Diet/Sleep History: Food allergies_____

Early sleep behavior: Sleepwalking, night terrors, dysregulation, etc. _____

Sexual development: Any suspected history of sexual acting out and/or sexual abuse?_____

Social Development: How was the client's attachment with mother growing up?_____

How was the client's attachment to father? _____

How is the client's ability to make, maintain good friendships?_____

Does the client have any significant hobbies or interests?_____

Behavior/Discipline: How compliant was/is the client as a child?_____

Any history of physical abuse?_____

Emotional Development: Any phobias/fears?_____ Any history of emotional abuse?_____

Drug/Alcohol use/abuse: Please list all usage:_____

_____

Self-Identity Development: How would you rate the client's self esteem on a scale from 1-10 (with 10 being the highest):_____

Medical History:

Please explain in detail current and past medical problems/concerns:_____

_____

_____

Current medications (with dosage, reason):_____

_____

Any side effects?_____

Are you happy with the current medication regimen?_____

How is the client's current diet? _____

Does the client exercise regularly? (If no, are there any limitations?)_____

How does the client sleep? (How many hours, is it interrupted, is there snoring, etc.)_____

Who is the client's Primary Care Physician?_____

Etc.

What are the client's personal strengths?_____

What are the major stressors in the client's life? Currently:_____

In the past:_____

What resources does the client have in aiding him/her in getting better?_____

_____

Is there anything else we should know about the client or his/her history or present situation that might help us better evaluate and help the client?_____

Thank you very much for your attention to this history/questionnaire. If you recall anything important after you complete it, please feel free to contact the clinician.