DEVELOPMENTAL HISTORY

Name _____

Child's Name _____

Relationship to Child _____

Child's Date of Birth _____ Current Grade _____

School of Attendance _____

Early Developmental History

Any problems with child during pregnancy? Yes _____ No _____

If yes, please explain. _____

Mother's age at birth _____ Father's age at birth _____

How was your child delivered? Vaginal Delivery _____ Cesarean-Section _____

Any problems with the child's birth or immediately after birth? Yes _____ No _____

If yes, please explain. _____

Please briefly describe your child before the age of 2 (i.e., calm, active, difficult, fearful, sad, happy, etc.) _____

Was it an easy or difficult attachment? _____

Please indicate the approximate ages of the following developmental milestones:

Sitting _____ Playing with others _____

Crawling _____ Sleeping through the night _____

Walking _____ Good eating habits _____

Talking _____ Counting _____

Toilet training _____ Writing _____

Talk in sentences _____ Reading _____

If needed, please explain any of the above ._____

_____

Family Composition

Who lives in the home with the child?

Name	*Age*	*Describe their relationship to the child?*

Siblings:

Name	*Age*	*Relationship to child (i.e. full, half, step adopted?)*

Parental Relationship:

Married _____ Date _____
Separated _____ Date _____
Divorced _____ Date _____
Never Married _____ Together? Yes _____ No _____
Mother Re-Married _____ Date _____ Spouse's Name _____
Father Re-Married _____ Date _____ Spouse's Name _____

Briefly describe the parental relationship (i.e., loving, co-operative, strained, turbulent, estranged) _____

_____

Behavioral History

Please describe your child's strengths _____

_____

_____

Please describe your child between the ages of 2-5 _____

_____

_____

Please describe your child between the ages of 6-9 _____

_____

_____

Please describe your child between the ages of 10-13 _____

_____

_____

Please describe your child between the ages of 14-18 _____

_____

_____

Does your child have behavioral problems at school? Yes _____ No _____

If yes, please explain. _____

_____

Does your child have behavioral problems at home? Yes _____ No _____

If yes, please explain. _____

_____

Does your child have any academic problems? Yes _____ No _____

If yes, please explain. _____

_____

Does your child receive Special Education Services? Yes _____ No _____

If yes, please explain. _____

_____

Does your child receive any other counseling? Yes _____ No _____

If yes, with whom? . _____

How many friends does your child have at school? _____

How much time do they play together per week? _____

How many friends does your child have at home? _____

How much time do they play together per week? _____

Medical History

Pediatrician's name _____

Date of child's last medical exam _____

Is your child on any medication? _____

Does your child wear glasses? Yes _____ No _____

Has your child ever been hospitalized? Yes _____ No _____

If yes, please explain. _____

_____

Has your child ever had a fever over 104 degrees? Yes _____ No _____

If yes, please explain. _____

_____

Has your child ever had any accidents or serious injuries? Yes _____ No _____

If yes, please explain. _____

_____

Family History

Does your child's family have any history of medical problems? Yes _____ No _____

If yes, please explain. _____

_____

Does your child's family have any history of emotional or psychological problems?

Yes _____ No _____

If yes, please explain. _____

_____

Does any member of your child's family have any current medical problems? \

Yes _____ No _____

If yes, please explain. _____

_____

Does any member of your child's family have any current emotional or psychological problems?

Yes _____ No _____

If yes, please explain. _____

_____

Are any members of your child's family currently using alcohol and/or drugs?

Yes _____ No _____

If yes, please explain. _____

_____

OVERVIEW OF EXPERIENCED SYMPTOMS: Please check those symptoms your child has experienced.

Symptom	Current	Past	Symptom	Current	Past
Headaches	_____	_____	**Restlessness**	_____	_____
Dizziness	_____	_____	**Decreased Sleep**	_____	_____
Stomach Trouble	_____	_____	**Mood Swings**	_____	_____
Health Problems	_____	_____	**Excess energy**	_____	_____
Pain	_____	_____	**Feeling Wired**	_____	_____
Tremors/tics	_____	_____	**Confusion**	_____	_____
Alcohol craving	_____	_____	**Elated mood**	_____	_____
Drug Craving	_____	_____	**Excessive spending**	_____	_____

EXPERIENCED SYMPTOMS (continued):

Symptom	Current	Past	Symptom	Current	Past
Eating problems	_____	_____	Racing thoughts	_____	_____
Sleep problems	_____	_____	Irritable	_____	_____
Weight loss	_____	_____	Impulsive behavior	_____	_____
Weight gain	_____	_____	Grandiose thoughts	_____	_____
Loss of appetite	_____	_____	Excessive anger	_____	_____
Feeling isolated	_____	_____	Panic attacks	_____	_____
Low energy	_____	_____	Anxiety	_____	_____
Feeling worthless	_____	_____	Physical abuse	_____	_____
Memory problems	_____	_____	Sexual abuse	_____	_____
Suicidal thoughts	_____	_____	Sexual problems	_____	_____
Planning Suicide	_____	_____	Relationship problems	_____	_____
Attempted suicide	_____	_____	Conflict in family	_____	_____
Crying a lot	_____	_____	Unable to have fun	_____	_____
Fears	_____	_____	Nightmares	_____	_____
Always worried	_____	_____	Fears of losing control	_____	_____
Concentration Problems	_____	_____	Unwanted thoughts or Behaviors	_____	_____
Hear voices others Do not Hear	_____	_____	See things others Do not See	_____	_____
Feel people plot Against you	_____	_____	Constant suspicion Distrust	_____	_____
Unusual thoughts	_____	_____	Strange experiences	_____	_____
Thoughts of Harming someone	_____	_____	Someone physically harming you	_____	_____
Violent /Aggressive Behavior	_____	_____			

Additional Information

Any major stressors that have occurred in your child's lifetime (i.e. death, illness, divorce, domestic violence, abuse, moving, addiction) _____

_____

List the three biggest stressors in your child's life currently_____

_____

Any additional information about your child that you would like to share _____

_____

_____

_____

_____

_____

_____