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Developmental History - Child

Patient Name: _____

First Middle Last

Date of Birth: _____

Today's Date: _____ Person Completing this Form:_____

Please describe your main concerns: _____

_____

_____

Family Information

Parents are: ❑Married ❑Separated ❑Divorced ❑Not married but live together ❑Not married and do not live together

Please list any step-parents or other adults involved significantly in caretaking: _____

_____

Please list siblings and ages: _____

_____

Please share any history of learning issues, depression/anxiety, ADHD or other mental health diagnoses in the immediate and extended family: _____

_____

Please describe any significant stressors that may be affecting your child: _____

_____

_____

Social Development

Briefly describe your child's personality:_____

_____

Please list any extracurricular activities: _____

_____

_____

Please describe any concerns about your child's social development: _____
_____
_____

Please describe any concerns about your child's behavior: _____
_____
_____

Developmental History

Was your son or daughter adopted? ❑Yes ❑No

Length of Pregnancy: _____ Birth Weight: _____

Please describe any complications during or after the pregnancy and delivery:

_____

_____

Did your child experience any delays in: ❑Motor development ❑Language development ❑Toilet training If yes, please explain: _____

_____

Did your child receive any early intervention services? Please explain: _____

_____

Medical History

Primary Care Physician:_____

Does your child have any: Medical problems? Vision problems? Hearing problems?
If so, please describe_____

Has your child ever been hospitalized? ❑Yes ❑No
If so, please describe_____

Is your child under the under the care of any other health professionals? ❑Yes ❑No

If yes, with whom? _____

Does your child have a current acute or chronic medical illness? ❑Yes ❑No

Diagnosis: _____

Has your child ever been given a psychological diagnosis? ❑Yes ❑No:

Diagnosis: _____

Is your child currently/has your child participated in therapy or counseling services in the past?

❑Yes ❑No If yes, with whom?_____

Does your child have a history of concussion? ❑Yes ❑No

If yes, when and how long before symptoms resolved? _____

_____

Please list any medications your child is currently taking: _____

_____

Do you have any concerns that your child may be using cigarettes, other nicotine products, alcohol, or illegal drugs? ❑Yes ❑No

If yes, please explain:_____

_____

Academic History

Current School: _____ Grade Level:_____

Other schools attended, beginning with preschool: _____

_____

Has your child ever skipped a grade? ❑Yes ❑No Been retained? ❑Yes ❑No

Has your child ever received tutoring services or been evaluated/testing for learning problems?

If yes, please describe: _____

_____

Is your child currently having academic difficulty? ❑Yes ❑No

If yes, please describe: _____

_____

Is your child experiencing behavioral problems in school? ❑Yes ❑No

Has your child ever been suspended? ❑Yes ❑No Or been expelled? ❑Yes ❑No

If yes to any of the above, please describe: _____

_____

Does your child have a 504 Plan, an IEP or a formal written learning plan on file at school?

Please describe the services your child receives: _____

_____

Is there any other information not covered on this form that you feel would be helpful or relevant? _____

_____

_____