



## DEVELOPMENTAL HISTORY FORM

Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Child's Birth \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Parent of Residence \_\_\_\_\_ Parent \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Home Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Age \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Highest Degree \_\_\_\_\_ Highest Degree \_\_\_\_\_

Religion \_\_\_\_\_ Religion \_\_\_\_\_

Marital Status:    M    S    D    W                      Marital Status:    M    S    D    W

If parents are divorced, which parent has **primary residential custody**? \_\_\_\_\_

Child's Siblings/Stepsiblings:	DOB	Age		
1. _____	_____	_____	M	F
2. _____	_____	_____	M	F
3. _____	_____	_____	M	F
4. _____	_____	_____	M	F

Others in the home \_\_\_\_\_

Person completing this form \_\_\_\_\_ Relationship to the child \_\_\_\_\_

What is the *primary* concern or reason for this referral? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BIRTH HISTORY:**

Child's weight at birth \_\_\_\_\_ Was the baby full term? \_\_\_\_\_ If not, how many weeks? \_\_\_\_\_

Were there any complications **during pregnancy**?  Yes  No

Explain: (*illness, injury, preterm labor, etc.*) \_\_\_\_\_

Where there any complications **during birth**?  Yes  No

Explain: (*breech, instruments needed, C-section*) \_\_\_\_\_

Where there any complications **after birth**?  Yes  No

Explain: (*jaundice, respiratory infections, feeding difficulties*) \_\_\_\_\_

Where there any other conditions present before, during or after birth that you feel were significant?

Yes  No

Explain: (*assisted reproductive technology*) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FIRST YEAR – TEMPERAMENT:**

- Easy baby
- Slow to warm up (*give examples*) \_\_\_\_\_
- Difficult baby (*give examples*) \_\_\_\_\_
- Activity level (*give examples*) \_\_\_\_\_

**DEVELOPMENTAL MILESTONES:**

First words at age \_\_\_\_\_

Speech and language delays and/or problems \_\_\_\_\_

Age your child began to walk \_\_\_\_\_

Eating habits \_\_\_\_\_

Sleeping habits as a baby \_\_\_\_\_

Current sleeping habits \_\_\_\_\_

Toilet training at age \_\_\_\_\_

Current problems with wetting or soiling? *(Please specify)* \_\_\_\_\_

Does your child suck his/her thumb?     Yes         No

Does your child masturbate?     Yes     No

Please elaborate \_\_\_\_\_

Do you have any concerns regarding your child's development? *(Please specify)* \_\_\_\_\_

**MEDICAL HISTORY:**

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last checkup? \_\_\_\_\_

How would you describe your child's health?     Excellent     Good     Fair     Poor

Has your child had a history of the following:

Chronic ear infections     Yes         No        How frequent? \_\_\_\_\_

Allergies     Yes     No    What is your child allergic to? \_\_\_\_\_ Treatment? \_\_\_\_\_

Is there any other medical information you think is important regarding your child? \_\_\_\_\_

Current Medications: *(list psychiatric and/or other medications – e.g. antiasthmatics, antibiotics, stimulants over the counter)*

Name of medication	How many mg or pills	Prescribing doctor and phone number	Reason for medication	Date began

**FAMILY HISTORY:** *(Please list all significant extended family and/or non-family members)*

Name	Age	Relationship <i>(briefly describe)</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Have any family members, including extended family experienced any of the following: *(Describe relationship to child)*

Developmental delays     Yes     No    *(Explain)* \_\_\_\_\_

Speech and language problems     Yes     No    *(Explain)* \_\_\_\_\_

Learning difficulties     Yes     No    Explain: \_\_\_\_\_

Is there a history of any emotional and/or addiction problems in the family? *(Please explain - e.g. grandfather was depressed, aunt was addicted to alcohol)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe any major changes or stresses in the family that have occurred. *(Please explain – e.g. financial difficulties, changes in housing, death, illness)*\_\_\_\_\_

**EDUCATIONAL HISTORY:**

Is your child currently attending a preschool program?  Yes  No Where?\_\_\_\_\_

How often does your child attending this program? \_\_\_\_\_

Has your child attended a preschool program in the past?  Yes  No

Where?\_\_\_\_\_ When?\_\_\_\_\_

Is your child currently receiving childcare from someone other than parents?  Yes  No

Please list the schools your child has attended beginning with:

Kindergarten\_\_\_\_\_

Elementary\_\_\_\_\_

Middle\_\_\_\_\_

High school\_\_\_\_\_

Does your child have an IEP?  Yes  No *(Explain)*\_\_\_\_\_

Does your child receive any **special services**?  Yes  No *(Explain – e.g. resource room speech language, etc)*\_\_\_\_\_

School contact person(s)\_\_\_\_\_ Phone\_\_\_\_\_

Teacher\_\_\_\_\_

Other\_\_\_\_\_

Does your child receive religious education?  Yes  No

Where?\_\_\_\_\_ When?\_\_\_\_\_

Does your child participate in any extra curricular activities?  Yes  No

Where?\_\_\_\_\_ When?\_\_\_\_\_

Is there anything else that seems significant to you that was not addressed elsewhere in this form?

Yes       No

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