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CHILD DEVELOPMENTAL HISTORY (AGES 11 and YOUNGER)

Child's Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____

Grade (if applicable): _____ School/Preschool: _____

Form completed by: _____

Relationship to child: _____ Date: _____

PRESENTING CONCERNS

In your opinion, what led to this referral? Check all that apply

- ☐ Developmental delays
- ☐ Symptoms of anxiety
- ☐ Thinking problems
- ☐ Adjustment to parents divorce
- ☐ Suspected abuse
- ☐ Suspected autism spectrum disorder
- ☐ Reading difficulties
- ☐ Behavior problems at home
- ☐ Other:_____
- ☐ Symptoms of depression
- ☐ Suicidal thoughts
- ☐ Difficulties with parents
- ☐ Problems with peers/poor social skills
- ☐ Refusal to attend school
- ☐ Fears/Anxiety
- ☐ Academic difficulties
- ☐ Behavior problems at school

How severe is/are the problem(s)? _____

_____

When were these problems first noted? _____

What concerns you most about your child? _____

_____

What do you find most difficult about raising your child? _____

_____

What is the best thing about your child? _____

_____

Has your child ever experienced any emotional, verbal, physical, or sexual abuse? _____

_____

_____

Any additional information? _____

_____

PREGNANCY and BIRTH

At the time of this child's birth, what was the mother's age?_____ Father's age_____

Did mother receive prenatal care? ☐None ☐ Yes - throughout entire pregnancy ☐ Some _____

Check any of the following complications that occurred during the pregnancy:

☐Measles ☐German measles ☐Excessive Swelling ☐Anemia ☐Toxemia ☐Vaginal bleeding ☐Flu

☐Rh Incompatibility ☐Abnormal weight gain ☐High Blood Pressure ☐Excessive Vomiting

☐Emotional Problems _____

☐ Stressors (describe) _____

☐ Other not listed: _____

Pregnancy Cont.			**If yes…**
Injury to Mother:	☐ Yes	☐ No	Describe:_____
Hospitalization during pregnancy	☐ Yes	☐ No	Reason:_____
X-ray during pregnancy:	☐ Yes	☐ No	What month:_____
Medications used during pregnancy:	☐ Yes	☐ No	Name:_____
Alcohol or other drugs used prior to discovering pregnancy	☐ Yes	☐ No	When was pregnancy discovered? _____
Alcohol used during pregnancy:	☐ Yes	☐ No	Frequency:_____
Cigarettes used during pregnancy:	☐ Yes	☐ No	Frequency:_____
Other drugs used during pregnancy:	☐ Yes	☐ No	Type and frequency:_____

Length of pregnancy:_____ **Length of labor:**_____

Length of stay in hospital? Mother:_____ Child:_____

Birth weight: _____lbs _____oz **Apgar Score(s)** _____

Child's condition at birth:_____

Mother's condition at birth:_____

Check any of the following complications that occurred during or after birth:

- ☐ Forceps used
- ☐ Labor induced
- ☐ Infection
- ☐ Cord wrapped around neck
- ☐ Need supplemental oxygen
- ☐ Incubator
- ☐ Breech birth
- ☐ Caesarean delivery
- ☐ Seizures
- ☐ Jaundice
- ☐ Ventilator
- ☐ Problems with heart
- ☐ Problems with bones
- ☐ Blood transfusion
- ☐ Cyanosis
- ☐ NICU stay
- ☐ Other:_____

DEVELOPMENTAL INFORMATION

Please indicate/estimate the age at which your child achieved the following milestones.

_____Turned over

_____Sat alone

_____Crawled

_____Stood alone

_____Walked alone

_____Walked up stairs

_____Walked down stairs

_____Showed an interest in/attraction to sound

_____Understood first words

_____Spoke first words

_____Toilet trained during the day

_____Toilet trained at night

Does your child continue to have toileting accidents? ☐**Yes** ☐**No**
If so, where does this happen? _____ How Often: _____

Were/are there any medical reasons for the toileting accidents? _____

Has your child experienced any of the following problems? If so please describe:

- ☐ Walking difficulty _____
- ☐ Unclear speech _____
- ☐ Feeding/ eating difficulties _____
- ☐ Underweight _____
- ☐ Overweight _____
- ☐ Difficulty learning to skip _____
- ☐ Difficulty learning to throw or catch _____
- ☐ Difficulty learning to ride a bike _____

During the first 4 years, were any of the following problems noted? If so, please describe:

- ☐ Eating _____
- ☐ Motor skills _____
- ☐ Sleeping too much _____
- ☐ Sleeping too little _____
- ☐ Temper tantrums _____
- ☐ Failure to thrive _____
- ☐ Separating from parents _____
- ☐ Excessive crying _____

Is your child? ☐**right handed** ☐**left handed** ☐**both** ☐**undecided**

Has your child lost any skills (e.g., use to say sentences but has now stopped)?

MEDICAL INFORMATION

Please check any of the following that your child has had, and indicate the age?

	Age		Age
☐ Measles	_____	☐ German Measles	_____
☐ Mumps	_____	☐ Rheumatic Fever	_____
☐ Chicken Pox	_____	☐ Diphtheria	_____
☐ Tuberculosis	_____	☐ Meningitis	_____
☐ Whooping Cough	_____	☐ Encephalitis	_____
☐ Anemia	_____	☐ Seizures	_____
☐ Diabetes	_____	☐ Asthma	_____
☐ Rashes	_____	☐ Hay fever	_____
☐ Eczema	_____	☐ Seasonal allergies	_____
☐ Broken Bones	_____	☐ Pneumonia	_____
☐ Food allergies	_____	☐ Frequent headaches	_____
☐ Stomach aches	_____	☐ Other	_____
☐ Head Trauma			

Hearing:			**Vision:**		
Frequent ear infections	☐ Yes	☐ No	Vision problems	☐ Yes	☐ No
Tubes	☐ Yes	☐ No	Wears Glasses	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No			
Sensitive to certain sounds	☐ Yes	☐ No	Sensitive to certain lights or colors	☐ Yes	☐ No
Has your child's hearing been evaluated?	☐ Yes	☐ No	Has your child's vision been evaluated?	☐ Yes	☐ No

Hearing Evaluation Results : _____ Date: _____
Who tested hearing? (e.g., doctor, school, ECI) _____
Vision Evaluation Results: _____ Date: _____
Who tested vision? (e.g., doctor, school, ECI) _____

Sleep

Past	Present	
☐	☐	No sleep difficulties
☐	☐	Trouble falling asleep
☐	☐	Wakes up frequently at night
☐	☐	Still tired after a good night's sleep
☐	☐	Does not get enough sleep
☐	☐	Restless in bed
☐	☐	Nightmares
☐	☐	Night terrors
☐	☐	Refuses to go to bed
☐	☐	Change in sleep pattern
☐	☐	Sleeps too much
☐	☐	Wakes up too early
☐	☐	Falls asleep in school
☐	☐	Refuses to get up in the morning
☐	☐	Snores
☐	☐	Sleeps with parent or sibling
☐	☐	Sleep Apnea (appears to hold breath when asleep)

Appetite

Past	Present	
☐	☐	Normal increase in weight/height
☐	☐	Unusual weight gain _____lbs.
☐	☐	Unusual weight loss _____lbs.
☐	☐	Concerns about height/growth?
☐	☐	Increase in appetite
☐	☐	Decrease in appetite
☐	☐	Gags on certain textures
☐	☐	Purposely throws up after eating
☐	☐	Food allergies _____
☐	☐	Eats excessively
☐	☐	Picky eater
☐	☐	Will only eat certain types of food._____
☐	☐	On a special diet_____

Please indicate if your child has ever had any of the following? If so describe.

- ☐ Seizure disorder _____
- ☐ Accident prone _____
- ☐ Bites nails or cuticles _____
- ☐ Sucks thumb _____
- ☐ Grinds teeth _____
- ☐ Has tics or twitches _____
- ☐ Bangs head _____
- ☐ Rocks back and forth _____
- ☐ Fever over 104 degrees _____
- ☐ Head injury _____
- ☐ Loss of consciousness _____

Current medications, indicate dosage:

_____ _____

_____ _____

Previous medications (Indicate when s/he stopped taking them):

_____ _____

_____ _____

Primary care physician: _____

Has your child ever had psychological or psychiatric exam? ☐ **Yes** ☐ **No**

Provider's name: _____
When: _____
Reason: _____

Has your child ever had psychological counseling or therapy? ☐ **Yes** ☐ **No**

Therapist's name: _____
When: _____
Reason: _____

Has your child ever had a neurological exam? ☐ **Yes** ☐ **No**

Neurologist's name: _____
When: _____
Reason: _____

Describe any hospitalizations and/or surgeries and the dates: _____

_____

Please indicate if any <u>family members</u> have had the following and specify that person's relationship to the child.

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Migraine headaches _____
- ☐ Physical handicap _____
- ☐ Tuberculosis _____
- ☐ Huntington's chorea _____
- ☐ Muscular dystrophy _____
- ☐ Sickle cell anemia _____
- ☐ Tay-sachs disease _____
- ☐ Tourette's syndrome _____
- ☐ Cerebral palsy _____
- ☐ Birth defect _____
- ☐ Alcohol abuse _____
- ☐ Drug abuse _____
- ☐ Behavior disorder _____
- ☐ Emotional problems _____
- ☐ Mental illness _____
- ☐ Mental retardation _____
- ☐ Nervousness _____
- ☐ Reading problems _____
- ☐ Learning disability _____
- ☐ Speech problem _____
- ☐ Language problem _____
- ☐ Severe head injury _____
- ☐ Other _____

TEMPERAMENT and BEHAVIOR:

Which describe your child's temperament before the age of two?

- ☐ Calm
- ☐ Alert
- ☐ Affectionate
- ☐ Angry
- ☐ Other_____
- ☐ Active
- ☐ Unhappy
- ☐ Crying
- ☐ Fearful
- ☐ Sociable
- ☐ Happy
- ☐ Difficult
- ☐ Cranky
- ☐ Withdrawn
- ☐ Tired
- ☐ Irritable
- ☐ Playful

Which describe your child now?

- ☐ Calm
- ☐ Tired
- ☐ Affectionate
- ☐ Withholds affection
- ☐ Tearful
- ☐ Active
- ☐ Cries a lot
- ☐ Difficult
- ☐ Happy
- ☐ Overreacts
- ☐ Sociable
- ☐ Irritable/Cranky
- ☐ Distracted
- ☐ Sad
- ☐ Moody
- ☐ Withdrawn
- ☐ Playful
- ☐ Funny
- ☐ Impulsive
- ☐ Worries
- ☐ Feels lonely often
- ☐ Self-conscious
- ☐ Even tempered
- ☐ Lacks self control
- ☐ Gets mad easily
- ☐ Hides Feelings
- ☐ Difficult to calm
- ☐ Easily upset by changes in routine
- ☐ Easily overstimulated
- ☐ Other _____

What is the best thing about your child?

_____

What makes your child angry?_____

Does your child have any specific fears? ☐ **Yes** ☐ **No**

Describe:_____

Does your child engage in any ritualistic or compulsive behavior? ☐ **Yes** ☐ **No**

Describe:_____

Has your child engaged in any of the following behaviors?

- ☐ None
- ☐ Stolen without confrontation
- ☐ Lies often
- ☐ Hits other children
- ☐ Destruction of property
- ☐ Used/tried to use a weapon in a fight
- ☐ Stolen with confrontation
- ☐ Tries to Run away
- ☐ Deliberate fire-setting
- ☐ Hits adults
- ☐ Cruel to animals
- ☐ Often initiates physical fights

What time does your child usually go to bed on school nights? _____

_____

Has your child ever experienced any emotional, verbal, physical, or sexual abuse?_____

_____

What do you find most difficult about raising your child?_____

_____

Who is mainly in charge of discipline at home? _____

Do all caregivers agree on discipline? _____

Which of the following methods of discipline are used at home?

- ☐ Verbal Reprimands
- ☐ Rewards
- ☐ Ignore behavior
- ☐ Other: _____
- ☐ Time out
- ☐ Physical punishment
- ☐ Discuss behavior
- ☐ Loss of privileges
- ☐ Give in to child
- ☐ Earn privileges

What discipline techniques are effective? _____

What discipline techniques are ineffective? _____ _____

Has your child experienced any of the following stressful events during the past year? Check all that apply

- ☐ Parents separated or divorced
- ☐ Parent changed jobs
- ☐ Family financial problems
- ☐ Other:_____
- ☐ Family accident or illness
- ☐ Changed schools
- ☐ Chronic health problems
- ☐ Death in the family
- ☐ Family moved

How many moves has your child had to make within the last three years? _____

FAMILY INFORMATION and RELATIONSHIPS

Mother's Name:	**Father's Name:**
Occupation:	Occupation:
Employer:	Employer:
Ethnicity:	Ethnicity:
Highest Grade Completed:	Highest Grade Completed:

Please list all persons residing with the family and their relationship to the child.

Name	Age	Gender	Relationship to child

If parents are divorced, separated, or not with the child, who has custody? _____

If child is not living with a parent, does s/he see this parent ☐ Yes ☐ No
If so, how often? _____

Primary language spoken by the child: _____

Primary language spoken at home: _____

How does your child relate to others? Check all that apply

- ☐ Has many close friends
- ☐ Has no close friends
- ☐ A follower
- ☐ Prefers younger children
- ☐ Interacts well with siblings
- ☐ Teases others
- ☐ Has friends who get in trouble
- ☐ Has several close friends
- ☐ Makes friends easily
- ☐ Fights with playmates
- ☐ Prefers older children
- ☐ Difficulty with siblings
- ☐ Feels rejected by peer group
- ☐ Wants friends, but doesn't know how to make or keep them
- ☐ Has few close friends
- ☐ A leader
- ☐ Prefers to play alone
- ☐ Prefers adults
- ☐ Teased by others
- ☐ Is jealous of others

Does your child ever say? check all that apply

- ☐ I like my friends
- ☐ Kids are fun
- ☐ I like my classmates
- ☐ I like recess
- ☐ I like sitting with friends at lunch
- ☐ No one likes me
- ☐ I don't have any friends
- ☐ I wish kids talked to me
- ☐ Kids hate me
- ☐ Kids make fun of me
- ☐ Kids pick on me

How does your child spend his/her free/play time? _____

_____

ACADEMIC INFORMATION

List the schools your child has attended?

_____

_____

Has your child been in a bi-lingual classroom? ☐ No ☐ Yes. If yes – how long? _____

Which of the following did your child attend? Check all that apply

- ☐ Infant day care
- ☐ Preschool
- ☐ Kindergarten
- ☐ None

Which of the following describe your child's kindergarten and first grade years? Check all that apply

- ☐ Enjoyed school
- ☐ Afraid of school
- ☐ Always in trouble at school
- ☐ Got along well with the teacher
- ☐ Frequently absent
- ☐ Active
- ☐ Disobedient
- ☐ Liked to help the teacher
- ☐ Felt neutral about school
- ☐ Complained of being sick to avoid school
- ☐ Disliked school
- ☐ Got along poorly with the teacher
- ☐ Aggressive
- ☐ Distractible
- ☐ Cooperative
- ☐ Lost temper easily

If applicable, which of the following describe your child's experiences since the first grade?
Check all that apply

- ☐ Good grades
- ☐ Failing grades
- ☐ Average grades
- ☐ Cooperative student
- ☐ Suspended, _____number of times
- ☐ Expelled, _____number of times
- ☐ Frequently absent
- ☐ Tested for special education
- ☐ Tested for the gifted program
- ☐ Tutored
- ☐ Retained, what year_____
- ☐ Loses temper easily

What are your child's current subject strengths?

- ☐ None
- ☐ Spelling
- ☐ Music
- ☐ Math
- ☐ Social Studies
- ☐ Athletics/PE
- ☐ History
- ☐ English
- ☐ Reading
- ☐ Art
- ☐ Science
- ☐ Other

What are your child's current subject weaknesses?

- ☐ None
- ☐ Spelling
- ☐ Music
- ☐ Math
- ☐ Social Studies
- ☐ Athletics/PE
- ☐ History
- ☐ English
- ☐ Reading
- ☐ Art
- ☐ Science
- ☐ Other

Which are your child's current skill strengths? Check all that apply

- ☐ None
- ☐ Concentration
- ☐ Organization
- ☐ Memorization
- ☐ Papers and reports
- ☐ Handwriting
- ☐ Checking work carefully
- ☐ Paying attention
- ☐ Getting assignments done
- ☐ Vocabulary/expression
- ☐ Understanding concepts
- ☐ Pleasing the teacher
- ☐ Reading speed
- ☐ Reading comprehension
- ☐ Working hard
- ☐ Completing homework
- ☐ Intelligence
- ☐ Behaving correctly
- ☐ Spelling
- ☐ Taking tests
- ☐ Turning in homework
- ☐ Test preparation
- ☐ Other

Which are your child's current skill weaknesses? Check all that apply

- ☐ None
- ☐ Concentration
- ☐ Organization
- ☐ Memorization
- ☐ Papers and reports
- ☐ Handwriting
- ☐ Checking work carefully
- ☐ Paying attention
- ☐ Getting assignments done
- ☐ Vocabulary/expression
- ☐ Understanding concepts
- ☐ Pleasing the teacher
- ☐ Reading speed
- ☐ Reading comprehension
- ☐ Working hard
- ☐ Completing homework
- ☐ Intelligence
- ☐ Behaving correctly
- ☐ Spelling
- ☐ Taking tests
- ☐ Turning in homework
- ☐ Test preparation
- ☐ Other

GOALS

What goals would you/your child like to accomplish in treatment?

1) _____

_____

2) _____

_____

3) _____

_____

4) _____

_____

5) _____

_____

Patient/Guardian Signature: _____ Date: _____

Psychologist/Therapist Signature: _____ Date: _____

CHILD SYMPTOM CHECKLIST

Please read each symptom/behavior listed and indicate how often your child has experienced it (frequency), and how long your child has experienced it (duration).

Symptoms	Rarely	3-4 times month	3-6 times week	Daily	How Long
1. Anxious, tense mood, difficulty controlling worry	**0**	**1**	**2**	**3**	
2. Panic attacks (intense and sudden fear)	**0**	**1**	**2**	**3**	
3. Anxiety and/or avoidance in social situations	**0**	**1**	**2**	**3**	
4. Specific intense fears (e.g. driving, needles, etc.) *Specify:*	**0**	**1**	**2**	**3**	
5. Obsessions and/or compulsions (excessive concern with cleanliness, orderliness, checking things, etc.).	**0**	**1**	**2**	**3**	
6. Fatigue, feeling tired even with good sleep	**0**	**1**	**2**	**3**	
7. Feeling worthless, low self-esteem	**0**	**1**	**2**	**3**	
8. Decreased interest in previously enjoyed activities	**0**	**1**	**2**	**3**	
9. Thoughts of suicide or death	**0**	**1**	**2**	**3**	
10. Excessive worry about weight/body image	**0**	**1**	**2**	**3**	
11. Irritable mood, snapping at others, easily angered	**0**	**1**	**2**	**3**	
12. Unexplained “up” mood, restless, lots of energy	**0**	**1**	**2**	**3**	
13. Impulsive behavior that your child wouldn’t “normally” do	**0**	**1**	**2**	**3**	
14. Racing thoughts that he/she cannot control	**0**	**1**	**2**	**3**	
15. Seeing/hearing things that are not real	**0**	**1**	**2**	**3**	
16. Recurrent, intrusive thoughts or images	**0**	**1**	**2**	**3**	
17. Easily startled, overly “watchful”	**0**	**1**	**2**	**3**	
18. Difficulty trusting others and feeling safe	**0**	**1**	**2**	**3**	