integrativepsychology

DEVELOPMENTAL HISTORY: CHILDREN / ADOLESCENTS

Please take the time to complete this form carefully. All information will be treated confidentially.

Child's Name_____ **Age**_____ **Birth date**_____ **Grade** _____
Address: _____ Telephone:_____
Sex: ☐ Male ☐ Female Ethnicity_____ Primary Language _____ Secondary language _____

Form Completed By: _____
If parents are separated or divorced, who has custody? _____
If applicable, how often does the child see his/her non-custodial parent? _____
Are there any legal or court proceedings related to this child? ☐ Yes ☐ No If yes, please explain:
_____

Mother's/Guardian's Name_____ Age_____
☐ Living with child ☐ Not living with child
Education_____ Occupation_____
Primary Language _____ Secondary language _____ Knows about appointment ☐ Yes ☐ No ☐ Not sure

Father's/Guardian's Name_____ Age_____
☐ Living with child ☐ Not living with child
Education_____ Occupation_____
Primary Language _____ Secondary language _____ Knows about appointment ☐ Yes ☐ No ☐ Not sure

Parents are ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Other_____

CONCERNS/REASON FOR EVALUATION
Describe your concerns and reason for seeking an evaluation at this time: _____
_____
_____
_____

Please describe when you first became concerned: _____
_____

FAMILY/HOUSEHOLD
What is this child's current living situation? _____
How long has he/she lived in this situation? _____
List all brothers and sisters, including any step- or half-siblings:

Name	Sex	Age	Relationship to child	Living in same home?

List any other relatives or non-relatives who live in the home, including relationship to the child:

_____

PREGNANCY & BIRTH

Length of pregnancy _____ (weeks) Length of labor _____ (hours) Age of mother at delivery _____
Child's weight at birth? _____lbs. _____oz. Child's health at birth?_____

Were there any complications during pregnancy with your child?

_____
_____

Check any of the following that occurred during or immediately following delivery:
☐ Induced labor ☐ Unplanned C-section ☐ Planned C-section ☐ Breech birth
☐ Incubator _____ (days) ☐ Jaundice ☐ Use of oxygen ☐ Other: _____

Additional information regarding pregnancy, delivery, or early weeks of life: _____
_____

ADOPTION

Is your child adopted? ☐ Yes ☐ No
If yes, at what age? _____ ☐ Domestic ☐ International (Country: _____)
What were the circumstances of your child's adoption? _____
_____
_____

DEVELOPMENTAL HISTORY

As accurately as you can remember, how old was your child when he/she met the following milestones?

Sat up alone	_____	First words	_____
Crawled	_____	Put two words together	_____
Walked alone	_____	Spoke in sentences	_____

Toilet trained: Age started_____ Age completed_____
Did/does child wet the bed? ☐ Yes ☐ No If yes, until what age? _____
Did/does soil the bed? ☐ Yes ☐ No If yes, until what age? _____

Was your infant ☐ Calm ☐ Fussy ☐ Colicky ☐ Easily comforted ☐ Hard to comfort?
Describe: _____
As an infant, were there any difficulties with ☐ Feeding ☐ Sleeping ☐ Bonding
Other? _____

Check any of the following areas in which the child has/had significant difficulties and describe briefly:
☐ Speech/Language: _____
☐ Gross motor (e.g., walking, running): _____
☐ Fine motor (e.g., buttons, scissors, holding a pencil): _____
☐ Sensory: _____
☐ Sleep: _____
☐ Eating: _____
☐ Temper tantrums: _____
☐ Separation from parents: _____
☐ Excessive crying: _____
☐ Social Skills: _____

☐ Other areas: _____

Does your child have any developmental delays or special needs? ☐ Yes ☐ No
Please describe: _____

Has your child had a previous developmental or psychological assessment? ☐ Yes ☐ No
Please describe: _____

Does your child receive any special services (*i.e.: Speech, O.T., Behavior Therapy, etc.)*? ☐ Yes ☐ No
Please describe: _____

Has your child ever received Birth to Three services? ☐ Yes ☐ No
Please describe: _____

Which hand does this child use for the following activities?
Writing or drawing: ☐ Right ☐ Left ☐ No preference (ambidextrous)
Holding a spoon to eat: ☐ Right ☐ Left ☐ No preference (ambidextrous)
Throwing a ball: ☐ Right ☐ Left ☐ No preference (ambidextrous)

HEALTH & MEDICAL HISTORY
Please list all medications your child takes. (Give name/dose/frequency) _____
_____

Check all that apply and indicate age at the time of illness or injury:
☐ Head injury with loss of consciousness Age: _____
☐ Head injury without loss of consciousness Age: _____
☐ Lyme disease Age: _____
☐ Seizures Age: _____
☐ Lead poisoning Age: _____
☐ Meningitis Age: _____
☐ Encephalitis Age: _____
☐ Coma Age: _____
☐ Sustained high fever Age: _____
☐ Broken bones Age: _____
☐Recurrent ear infections Age: _____
☐ Other major illness, injury, or surgery _____

Has your child had a hearing screening? ☐ Yes ☐ No Age:_____ Results:_____
Has your child had a vision screening? ☐ Yes ☐ No Age:_____ Results:_____

CURRENT MEDICAL CONCERNS If "**Yes**", give brief description or explanation:

Allergy to medication	☐ Yes ☐ No	_____
Allergy to food	☐ Yes ☐ No	_____
Seasonal allergies	☐ Yes ☐ No	_____
Frequent colds	☐ Yes ☐ No	_____
Frequent ear aches	☐ Yes ☐ No	_____
Frequent stomach aches	☐ Yes ☐ No	_____
Excessive vomiting	☐ Yes ☐ No	_____
Intestinal problem	☐ Yes ☐ No	_____
Bladder control	☐ Yes ☐ No	_____

Bowel control ☐ Yes ☐ No _____
Asthma ☐ Yes ☐ No _____
Heart condition ☐ Yes ☐ No _____
Scoliosis ☐ Yes ☐ No _____
Other current medical ☐ Yes ☐ No _____

SOCIAL RELATIONSHIPS

Fights frequently with peers ☐ Yes ☐ No Comments: _____
Has difficulty making friends ☐ Yes ☐ No Comments: _____
Has a preferred group of friends ☐ Yes ☐ No Comments: _____
Prefers to play with older children ☐ Yes ☐ No Comments: _____
Prefers to play with younger children ☐ Yes ☐ No Comments: _____
Prefers to play alone ☐ Yes ☐ No Comments: _____
Easily over-stimulated in play ☐ Yes ☐ No Comments: _____
Overly energetic in play ☐ Yes ☐ No Comments: _____
Overreacts when faced with problems ☐ Yes ☐ No Comments: _____
Unhappy or sad much of the time ☐ Yes ☐ No Comments: _____
Irritable or easily angered much of the time ☐ Yes ☐ No Comments: _____
Lacks self-control; impulsive ☐ Yes ☐ No Comments: _____
Smokes cigarettes or chews tobacco ☐ Yes ☐ No Comments: _____
Inhales toxic substances (e.g., paint) ☐ Yes ☐ No Comments: _____
Uses illegal drugs ☐ Yes ☐ No Comments: _____
Drinks alcohol ☐ Yes ☐ No Comments: _____

Role in peer group activities ("leader", "follower", "just watches", etc.): _____

How would you describe your child's relationships with his/her peers? _____
_____

How would you describe your child's relationships with his/her siblings? _____
_____

How would you describe your child's relationships with his/her parents? _____
_____

INTERESTS, HOBBIES, SPORTS

List child's interests and activities: _____
Does your child attend regular groups or classes? _____
Has there been a change or decline in activities recently? ☐ Yes ☐ No Describe: _____

TEMPERAMENT

What best describes your child's temperament?	*(please circle)*
Energy:	Quiet ---------- Very active
First Reaction (to new people, activities, ideas):	Outgoing, jumps right in ---------- Shy, holds back
Mood (general emotional tone):	Usually positive, happy ---------- More serious, analytical
Intensity (strength of emotional reactions):	Has mild reactions ---------- Has strong reactions
Persistence (ease of stopping when involved in an activity):	Easily redirected ---------- "Locks in"
Sensitivity (to noises, emotions, tastes, textures, stress):	Usually not sensitive ---------- Very sensitive
Perceptiveness (notices people, noises, objects):	Hardly ever notices ---------- Very perceptive
Adaptability (copes with transitions, changes in routine):	Flexible, adapts quickly ---------- Adapts slowly
Regularity (regular about eating,sleeping times, etc.):	Regular, follows routine ---------- Irregular
Attention Span/Distractibility (follow through w/ tasks):	Stays focused ---------- Easily distracted

MENTAL HEALTH HISTORY

Has child experienced any of the following? If "yes", indicate the age of the child at the time:

Parental separation? ☐ Yes ☐ No Age: _____
Parental divorce? ☐ Yes ☐ No Age: _____
Parental death? ☐ Yes ☐ No Age: _____
Death of sibling? ☐ Yes ☐ No Age: _____
Other significant loss? ☐ Yes ☐ No Age: _____
Witness of a traumatic event? ☐ Yes ☐ No Age: _____
Victim of a traumatic event? ☐ Yes ☐ No Age: _____

If yes to any of the above, please describe:

Has your child ever received services from a mental health professional (e.g.: psychologist, social worker, counselor, therapist, psychiatrist)? ☐ Yes ☐ No Age: _____
If yes, please describe (include type and dates of treatment):

Has your child ever been hospitalized for psychiatric treatment? ☐Yes ☐No
If yes, please describe (include dates of hospitalization):

FAMILY HEALTH HISTORY

Do you or anyone in your family have medical or psychiatric difficulties? ☐Yes ☐No
If yes, please indicate those that apply:

☐ Diabetes ☐ Hypertension ☐ Hypotension ☐ Cancer ☐ Stroke ☐ Liver Disease ☐ Asthma
☐ Other:_____
☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Bipolar Disorder ☐ Suicide ☐ Autism/PDD
☐ Substance Abuse ☐ Attention Difficulties ☐ Social Difficulties ☐ Learning Differences
☐ Other:_____

Additional Comments:

ACADEMIC HISTORY

Current school: _____ Grade: _____

List all schools attended and **give reason for any changes** other than normal progression:

_____

_____

_____

_____

_____

Pre-school or daycare? ☐ Yes ☐ No Describe how your child responded to separation at that time: _____

Kindergarten? ☐ Yes ☐ No Describe any problems: _____

Ever repeat a grade? ☐ Yes ☐ No Details: _____

Ever skip a grade? ☐ Yes ☐ No Details: _____

Problem learning to read? ☐ Yes ☐ No Details: _____

Current reading problem? ☐ Yes ☐ No Details: _____

Difficulty with math? ☐ Yes ☐ No Details: _____

Placed in Special Ed? ☐ Yes ☐ No Details: _____

Placed in gifted classes? ☐ Yes ☐ No Details: _____

Frequent absences? ☐ Yes ☐ No Details: _____

Frequent tardiness? ☐ Yes ☐ No Details: _____

Behavior problems? ☐ Yes ☐ No Details: _____

Tutoring? ☐ Yes ☐ No Details: _____

Speech therapy? ☐ Yes ☐ No Details: _____

Problems with homework? ☐ Yes ☐ No Details: _____

Has an IEP? ☐ Yes ☐ No Details: _____

Has a 504 Plan? ☐ Yes ☐ No Details: _____

If your child has an IEP or 504 Plan, what grade did these services begin? _____

If applicable, describe nature of supports and accommodations: _____

_____

_____

Grades in elementary school: ☐ Mostly A's ☐ A/B ☐ B/C ☐ C/D ☐ Comments: _____

Grades in middle school: ☐ Mostly A's ☐ A/B ☐ B/C ☐ C/D ☐ Comments: _____

Grades in high school: ☐ Mostly A's ☐ A/B ☐ B/C ☐ C/D ☐ Comments: _____

What do you consider this child's greatest strengths and talents? _____

_____

What areas challenge your child? _____

_____

What is your child's relationship like with his/her teachers? _____

_____

PARENT COMMENTS

What strengths does your child possess? _____

_____

_____

_____

Do you have any additional comments about your child? _____

_____

_____

_____

Thank you for taking the time to complete this form.