Kids Inc.

Helping children develop

Child's Developmental History

Completed by:____ Date________________________
(name and relationship to client.)

Child's Name:______________________________________ Birthdate:______________
Male/Female:___________________ Age:_____________
Is the child adopted? ☐Yes ☐ No If so, at what age?________________

Home Address _____________________________________ Home Phone ________________________

School ____Grade:_____________________

Were any grades skipped? ☐ Yes ☐ No
Were any grades repeated? ☐ Yes ☐ No Which ones?_____________________

Father's Name ______________________________ Age __________ Education ___________________

Employment ____Work Phone _________________

Mother's Name _____________________________________ Age ___________ Education __________________

Employment ____Work Phone _________________

Other children in the home:

Name & Age __________________________ Name & Age ________________________

Name & Age __________________________ Name & Age ________________________

Emergency Contact Person:____
Emergency Contact Phone Number:____
Relationship to child:____

Who else lives in the home? (Please include name, relationship to the child.)

____
____
____

Are there close family members not living in the home? ☐ Yes ☐ No
(Biological/step parents or siblings; list name, relationship to the child, age of brother/s sisters or other children)

____
____
____

What concerns or issues convinced you to seek assistance now?________________________
____

The problem has been going on for how long? (weeks, months, one year, two years or longer?)

____

 Child's Name: ________________________

My child has the following problems at home (i.e. aggressive behavior, sad mood, anxiety, risk taking behavior, bedwetting). Please list and describe: ___________________________________

____

My child has the following problems at school (i.e. learning, behavior, peer problems). Please list and describe: ____

____

My child has the following problems in other situations: ___________________________________

____

____

My child has had the following problems (behavior, learning, emotional) in the past:

____

____

What treatment has been received for these problems? ___________________________________

____

Current or past stressors that may be contributing to my child's problems are the following (i.e. marital conflict or divorce, abuse, death in the family): ___________________________________

____

____

FAMILY HISTORY

Is there anyone in the extended or immediate family who has similar symptoms or problems as the child? Yes No
Please specify:____

____

____

Is there a family history of substance abuse in your family? Yes No
Please specify:____

Name and describe those family members (immediate and extended) who have a history of behavior, learning, drugs/alcohol and/or psychiatric problems (depression, highs and lows, hyperactivity, major mental illness):

____

____

PREGNANCY HISTORY - Mother

While pregnant with this child was the mother under a doctor's care? ☐ Yes ☐ No

Mother's health during pregnancy: _____ Good _____ Fair _____ Poor
If fair or poor, please describe:____

____

Child's Name: ________________________

During pregnancy; did the mother:

Take any medications? ☐ Yes ☐ No Please List: ______________________
Drink Alcohol? ☐ Yes ☐ No How Much? ______________________
Smoke cigarettes? ☐ Yes ☐ No How Much? ______________________
Use recreational drugs? ☐ Yes ☐ No What/how much? __________________

During the pregnancy were there any complications (i.e. bleeding, emotional stress, high blood pressure, fetal distress)? ____

Length of pregnancy:____________ Birth weight:_______ Apgar Score: (Scale from 1-10) ______
Duration of labor:____________ Were forceps used? ☐ Yes ☐ No
Delivery was (check one) _____ Normal _____Breech _____ Cesarean
Were there any problems before or after delivery? ☐ Yes ☐ No
If so, please describe:____

DEVELOPMENTAL HISTORY

As well as you can remember, were there any delays in the following areas?

	Yes	No		Yes	No
Sat alone	☐	☐	Toilet Trained	☐	☐
Named colors	☐	☐	Crawled	☐	☐
Rode bike	☐	☐	Said alphabet	☐	☐
Stood along	☐	☐	Used sentences	☐	☐
Began to read	☐	☐	Walked along	☐	☐
Buttoned clothes	☐	☐	Tied shoes	☐	☐
Said words (besides mama, dada)	☐	☐			

Age held head up ________ Age turned over ________ Age smiled at parents _______________
Age crawled ______ Age able to sit _____ Age pulled up in crib _____ Age walked alone _______
Any feeding or eating problems? Explain: ____
____

Bottle-fed _________________ Breast-fed ________________ Age weaned _______________
Any speech or language problems? Explain: ______________________________________
____

Age used 4-10 words? _____________________ Age used sentences? _____________________
Age said "NO" to everything _________ Timid or shy? ______________ Affectionate baby? ____
Friendly baby? __________ Liked attention? _______________Wanted to be left alone? ______
More interested in things than people? ______ Stubborn? ____________ Irritable? ___________
Any problems with toilet training? Explain: _______________________________________
____

Dry at what age? __________________ Bowel trained at what age? ____________________
Describe activity level as an infant; a toddler; older child: ________________________________
____
____

 Child's Name: ________________________

Age helped with dressing? _________ Age dressed alone? _____ Fed self at what age? ________
Right or left handed? _____ Age at which this issue was settled? ____ Good with hands? ________
Well coordinated?_____ Good gross motor skills? _____ Good fine motor skills? _____________
Clumsy? ____________
List and describe any sleep problems (difficulty falling asleep; staying or returning asleep) at the present time or in the past? ____

____

____

Is there a history of the following? What age?

______ Blank spells ______ Falling spells ____ Fainting spells
______ Daredevil behavior ______ Impulsive behavior _____ Unusual fears
______ Rocking behavior ______ Head bumping _____ Temper tantrums

MEDICAL HISTORY

List and explain your child's current or past medical or neurological problems. Include head injuries, seizures, heart problems, disabilities, asthma etc. ________________________________

____

____

Has your child ever been hospitalized: ☐ Yes ☐ No
If so, when and why?____
Last Physical:_______________ Child height:____________ Weight:___________
Name of primary care physician?____
Is your child on any prescribed or over the counter mediations? ☐ Yes ☐ No
Prescribed by: __________________________
If so, what is the medicine, the dosage and how long has your child been on it?_______________
____

Has your child received any previous counseling or mental health treatment? ☐ Yes ☐ No
List and describe all past psychiatric and counseling situations both inpatient and outpatient:

THERAPIST/PSYCHIATRIST	TREATMENT	RESPONSE

To your knowledge has your child tried any of the following?

Tobacco ☐ Yes ☐ No
Alcohol ☐ Yes ☐ No
Street or Recreational Drugs ☐ Yes ☐ No
Over the Counter Drugs ☐ Yes ☐ No
If yes please name____

Is there any history of abuse (emotional, physical, sexual)? Explain:

____

 Child's Name: ________________________

Is there a history of, or current concern with any of the following (please check). For each item checked, please list how long these have been problems.

___________ School Behavior Problems	___________ Academic/Special Education
___________ Eating problems	___________ Stealing
___________ Speech Difficulties	___________ Masturbation
___________ High temperatures	___________ Runaway
___________ Head injuries/concussions	___________ Temper tantrums
___________ Poor memory	___________ Crying spells
___________ Wetting pants	___________ Cruel to animals
___________ Soiling pants	___________ Coordination
___________ Lying	___________ Truancy
___________ Avoids cuddling	___________ Impulsivity
___________ Sleep difficulties	___________ Interrupting
___________ Headaches	___________ Poor attention
___________ High energy	___________ Bed wetting
___________ Constipation	___________ Fire setting
___________ Sex play with other children	___________ Frequent bad dreams
___________ Aggressive behavior	___________ Defiance to authority
___________ Legal problems	___________ Obsessive Behavior
___________ Fears	___________ Suicidal thoughts
___________ Attention Deficit Disorder	___________ Hallucinations
___________ Bizarre Behaviors	___________ Other

What stressors are affecting your child?

Home _________________	Parent Conflict _________________
Peer _________________	Family _________________
School _________________	Siblings/Step _________________
Grades _________________	Step Parent _________________
Other _________________	Losses _________________

How does your child get along with other children (Please circle) Good Fair Poor

School ____

Home ____

Do you have any concerns about their friends? ☐ Yes ☐ No

What does your child and family do for fun?: (Please Check)

Games:____ Outing:____ Movies:____ Sports:____ School Functions:_____ Other: ______

What are your child's assets? (Please Check)?

Academics:__________ Music:________ Art:__________

Sports:___________ Helpful:_________ Good-natured:_____________

Plays well with others:___________ Cooperative:___________

Other:____

Please make any other comments what may be helpful in understanding your child