PT NAME _____ DOB____/ ___/___ DATE ___/____/___

Child/Adolescent Developmental History

(for ages 17 and younger)

Pt Age: _____ Gender : _____

Any Allergies : Environmental or Medications? ❑ Yes ❑ No

List:_____

Is your child adopted: ❑ Yes ❑ No

If "Yes", please explain the following : Reason and circumstances; Age when child first in home; Date of legal adoption; What has child been told_____

Does or did any member of the family have problems with ❑Reading ❑Spelling ❑Math ❑Speech ❑Motor Skills.

If "Yes", explain: _____

Does your child have any specific learning disability❑ Yes ❑ No

If "Yes", explain: _____

FAMILY HEALTH HISTORY: Do not include info for the child

FAMILY HISTORY Includes:

Diabetes	High Blood Pressure	Heart Attack/Heart Disease	Blood Clots /Stroke	Tuberculosis
Cancer	Alzheimer's	Family History Unknown	Mental Illness	Epilepsy/Seizure
Thyroid	Migraines	Autoimmune Disorders		

Name	Relation	Illness

CHILD HEALTH INFORMATION:

Child's Current Height_____ Current Weight _____(Give best estimate)

Do s/he eat three meals a day? ❑ Yes ❑ No Does s/he eat from all food groups? ❑ Yes ❑ No

Is eating or weight a problem ❑ Yes ❑ No If yes explain:_____

SLEEP : hours per day _____

Difficulty falling asleep? ❑ Yes ❑ No

Difficulty staying asleep? ❑ Yes ❑ No

Sleep in own bed? ❑ Yes ❑ No

Night Terrors or Sleep walking? ❑ Yes ❑ No

Is sleeping a problem? ❑ Yes ❑ No

Current or past health issues of your child should be listed here.

	age		age		age
___ High fevers		___ Dizziness		___Anxiety	
___ Pneumonia		___ Tonsils out		___Temper outbursts	
___ Flu		___ Vision problems		___Fears	
___ Encephalitis		___ Hearing problems		___ Hyperactivity	
___ Meningitis		___ Earaches		___Weight problems	
___ Convulsions		___ Dental problems		___ Poor eating habits*	
___ Unconsciousness		___ H or L blood pressure		___ Unusual sleeping patterns*	
___ Concussion*		___ Sinus problems		___Suicide thoughts	
___ Head Injury*		___ Skin problems		___Suicide attempts	
___ Fainting		___ Asthma		___Thoughts of harming others	
___ Diarrhea		___ Headaches		___Head banging	
___ Constipation		___ Stomach problems		___Rocking	

PT NAME _____ DOB____/ ___/___ DATE ___/____/___

___ Aches and Pains		___ Heart problems		___Crying spells	
___ Frequent Colds		___Sibling rivalry		___Morbid thoughts	
___ Anemia		___Daydreaming		___Mood swings	
___ Accident prone*		___Decrease in energy or Interest		___Hurts self (cuts burns scratches)	

Any history of seizures or seizure-like activity ? ❑ Yes ❑ No

_____

Any periods of spaciness or confusions? ❑ Yes ❑ No

_____

Any history of accidents resulting in broken bones, lacerations, severe bruises ? ❑ Yes ❑ No

_____

Prior abnormal lab tests, X-rays, EEG, CT/MRI, etc.? ❑Yes ❑ No

_____

Please list anything not listed in the above chart and add comment to those items marked with an " ***** " :

_____

_____

Was your child ever hospitalized? ❑ Yes ❑ No (List the hospitalizations for Medical Illness, Injury, Surgery)

Date / Age	Place	Cause

Was your child ever seen by a medical specialist? ❑ Yes ❑ No

Date / Age	Type of Specialist	Cause

DEVELOPMENT HISTORY:

PRENATAL:

Was the pregnancy planned for ? ❑ Yes ❑ No
Conception problems? ❑ Yes ❑ No
Did the birth mother experience any physical or emotional problems during pregnancy?
❑Yes; specify _____
❑No ❑Unknown

Were medications taken during pregnancy?
❑Yes; specify _____
❑No ❑Unknown

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?
❑Yes; specify _____
❑No ❑Unknown

BIRTH:

Length of active labor ____ # or hours; ❑Easy or ❑Difficult
Length of pregnancy: _____ (normal is 40 weeks)
Birth weight _____ lbs _____oz
Type of delivery: ❑spontaneous ❑c-section ❑w/instruments
❑head first ❑ breech

PT NAME _____ DOB____/ ___/___ DATE ___/____/___

Physical condition of infant at birth: ❑Good ❑Complications:
Describe_____

NEW BORN PERIOD:

Irritability	❑ Yes	❑ No	Vomiting	❑ Yes	❑ No
Difficulty Breathing	❑ Yes	❑ No	Difficulty Sleeping	❑ Yes	❑ No
Convulsions/Twitch	❑ Yes	❑ No	Colic	❑ Yes	❑ No
Normal Weight Gain	❑ Yes	❑ No	Breast fed	❑ Yes	❑ No

DEVELOPMENTAL MILESTONES:

Motor Development (please write age, parentheses are approximate normal limits)
Rolls over (3-5 months) _____ Sits without support (5-7 months) _____ Crawls (5-8 months) _____
Walks well (11-15 months) _____ Runs well (2 years) _____ Rides tricycle (3 years) _____
Current activity level _____
Fine motor coordination (writing, drawing) _____
Gross motor coordination (running, jumping, balance) _____
Compared to peers _____

Language Development (please write age, parentheses are approximate normal limits)
Several words (besides mama, dada) (1 year) _____ Three word sentences (2 years) _____
Vocabulary _____ Articulation _____ Comprehension _____
Compared to peers _____

Social Development (please write age, parentheses are approximate normal limits)
Smile (2 months) _____ Shy with strangers (6-10 months) _____ Separates easily (2-3 years) _____
Cooperative Play (4 years) _____ Imaginative Play _____
Describe quality of attachment to mother _____
Describe quality of attachment to father _____
Early peer relationships?
_____
Relationship to family members? _____
Quantify the number of friendships your child has NOW: ❑A lot of friends; ❑Few friends; ❑No friends
Describe your child's friendships:
_____
How would your characterize your child's behaviors or preferences when dealing with other children now?
❑Individual play vs. ❑Group play
❑Competitive vs. ❑Cooperative
❑Leader vs. ❑Follower

Toilet Training
Age reached bowel control: Day _____ Night _____ Age reached bladder control: Day _____ Night _____
Any problems related to toilet training ? (Did the child return to wetting or soiling at any time?) ❑ Yes ❑ No
Describe :_____

Sexual Development
Gender identity concerns? _____

Behavior/Discipline
Compliance versus noncompliance ?_____ Lying/Stealing _____
Methods of discipline (Please list methods used i.e. Verbal reprimands, time out, removal of privileges/rewards)
_____
_____

Emotional Development
What was their early temperament like? _____
_____

PT NAME _____ DOB____/ ___/___ DATE ___/____/___

Current personality? _____

Moods ? _____

Describe your child's approach to new situations?

❑Positive, jumps right in; ❑Slow to warm up; cautious ❑Withdrawn, tends not to participate

Their ability to express feelings? ❑With ease ❑Has difficulty

Describe any special habits, phobias, fears, or idiosyncrasies of your child:

_____

Is there any history of physical, sexual or emotional abuse?

❑Yes; specify _____

❑No ❑Unknown

Is there a history of prolonged separations or traumatic events?

❑Yes; specify _____

❑No ❑Unknown

EDUCATIONAL HISTORY:

Which school is your child currently attending? _____Current Grade Level _____

Has your child ever failed a class or been held back for academic reasons?

❑Yes; specify grade: _____ ❑No

Is your child currently receiving special services in this school?

❑ Yes ; specify _____ ❑ No

Has your child had special testing in school: ❑ Yes ❑ No

If yes, (Psychological, Vocational, Speech) and what were the results

_____

Does your child attend school on regular basis ❑ Yes ❑ No

Does your child appear motivated for school ❑ Yes ❑ No

Has your child ever been suspended or expelled ❑ Yes ❑ No

Is your child expected to pass this school year? ❑ Yes ❑ No

ACADEMIC PERFORMANCE:

Highest grade on report card? _____ Lowest Grade _____

Favorite Subject_____ Least Favorite Subject_____

What are your child's educational aspirations: ❑ Quit school ❑ Graduate from High School ❑Go to College

Does child participate in extracurricular activities ? ❑ Yes ❑ No

List: _____

List Child's special interests, hobbies, skills, strengths and weaknesses:

_____

_____

_____

_____

MEDICATIONS

Please complete down to the dotted line.

Please list all Prescribed Medications/ Over the Counter Meds / Vitamins / Herbal Supplements that your child is currently taking.

Date Begun	Medication	Reason	Dosage	Times per day	Prescribing Doctor

PT NAME ____ DOB____/ ___/___ DATE ___/____/___

To the best of your ability, please list any PAST psychotropic medications and the results;

Medication	Reason	What was the response

Parent Signature:____Date _________________

*For clinician use below this line

Note :

____

____

____

Reviewed by ____ Date:___________________

For clinician use below this line: Medication Updates

- -

Date begun	Medication	Reason	Dosage	Times per day	Prescribing Doctor / Note