CLIENT INFORMATION & DEVELOPMENTAL HISTORY

Date:

Child's Name:_____Age:___ DOB:_____

School:_____Grade:___ Teacher:_____

Person providing information:
Respondent's Name & Relationship to Child:_____

Home Phone:_____Alternate Phone #:_____

Best day and time to reach you?_____At what Number?_____

Referral Information:
Briefly describe why you are seeking help:_____

_____

_____

Who referred You?_____

Policy Holder Information (If different from Patient)

Insurance Name:_____Id #_____ Group #_____

Parent Information:

Mother's Name:_____Stepmother? No Yes

Address:_____ Phone Number_____

Employer:_____Occupation:_____How long with employer:__

Father's Name:_____Stepfather? No Yes

Address:_____ Phone Number_____

Employer:_____Occupation:_____How long with employer?___

Does the child have other parent(s) or stepparent(s)? Yes No

Name(s):_____Relationship(s)_____ Phone Number:

Pregnancy/Birth

Where (city/state) was this child born?_____

Was the child a planned pregnancy? Yes No

Mother's age at this child's birth?_____Father's Age_____

Was the mother under the care of a physician at this time? Yes No

What number child is this born to his/her biological parents? _____Out of_____

Check any of the following complications that occurred during pregnancy with this child

__Difficulty in conception __Excessive vomiting __German measles
__Measles __excessive swelling __Emotional problems
__High Blood Pressure __Anemia __Other:_____
__Maternal Injury-What_____ __Hospitalization during pregnancy Why?_____
__Medications used during pregnancy-What?_____Caffeine Use_____What?_____
__Alcohol Use during pregnancy-How much?_____
__Cigarettes used during pregnancy-How many?

Other drugs used during pregnancy:

Type	Frequency	Prescription
_____	_____	Yes No
_____	_____	Yes No
_____	_____	Yes No

Length of Pregnancy: Birth Weight:___lbs.____oz.
Length of Labor Length at Birth:_____

Check any of the following complications that occurred during birth.

__Breech birth __Labor induced
__Caesarean delivery __Incubator: How Long?_____
Breathing problems right after birth:___Describe_____
Supplemental oxygen? Yes No If yes, how long?
Was anesthesia used during delivery? Yes No What kind?_____

Name and address of hospital where delivery took place:_____

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

Development

At what age did this child first do the following? *Please indicate year/month of age*.

_____Turn over	_____Walk down stairs
_____Sit alone	_____Show interest in sound
_____Crawl	_____Understand first words
_____Stand alone	_____Speak first words
_____Walk up stairs	_____Speak in sentences

Was child breast-fed/bottle fed?_____ When weaned?_____

When was child toilet trained? Days_____Nights_____

Did bed-wetting and or bed soiling occur after toilet training?___If yes, until what age?

Was there any medical reasons for the bed wetting or soiling? If yes, please describe.

_____

Circle any problems this child has experienced & describe on the lines below.

Walking Unclear speech Feeding Underweight/overweight problems Colic Sleep problems Eating disorder Difficulties learning to skip, throw, catch, ride a bike. Describe the problems._____

Has child had any of the following during the first 4 years of life?

Eating, Motor skills, sleeping too much, temper tantrums, sleeping too little, excessive crying, failure to thrive, separating from parents
Describe:_____

Medical History

Childhood illness/injuries: Measles, German measles, mumps, chicken pox, tuberculosis, Whooping cough, scarlet fever, head injury (Coma or loss of conscientiousness), sustained high fever, Rheumatic fever, Diphtheria, Meningitis, Encelphalitis, anemia, Fever above 104: Describe_____

Medical History (Continued)

Has this child been on long-term medications (more than 6 months)? Yes No
If yes, what kind and how often are they administered?_____

Please circle if child has or had any of these medical problems:
Respiratory: frequent colds, chronic cough, asthma, hay fever, sinus condition
Cardiovascular: shortness of breath or dizziness with physical exertion, activity limitations due to heart conditions, heart murmur
Gastrointestinal: excessive vomiting, frequent diarrhea, constipation, stomach pain
Genitourinary: urination in pant or bed, pain while urinating, excessive urination, strong urine odor
Musculosketal: muscle pain, clumsy walk, poor posture, other muscle problem
Skin: frequent rashes, bruises easily, sores, severe acne, itchy skin, eczema
Neurological: seizures/convulsions, speech deficits, accident prone, bites nails, sucks thumb, grinds teeth, has tics/twitches, bangs head, rocks back & forth, bowel movements in pants or bed, taken meds to increase activity, taken tranquilizing medication.
Allergies: allergic to medicine, food, other
Hearing: ear infections, hearing problems, ear tubes. Most recent hearing test?_____
Vision: vision problems, wears glasses or contacts. Most recent eye exam?_____

Child's primary care physician:_____Phone:_____
Address:_____

How often does this child see the doctor?_____Date of Last Visit_____
Is child currently on medication? Yes No
If yes, indicate type & reason_____

Has this child ever had psychological counseling or therapy? Yes No If yes, where, with whom and how long?_____
Why did child stop?_____

Does child have a history of alcohol/substance abuse? If yes, explain_____

Has child ever had a neurological exam?_____ If yes, explain._____

Has this child ever had psychological or psychiatric evaluations?___Do you have a copy of the results?

Family History

Is this child closer to one parent (caregiver) than another?_____ If Yes, which one?
Has this child ever experienced any parental separations, divorces, or death? If yes, When?_____ How old was the child at the time?_____Please describe the
circumstances._____

If parents separated or divorced, who has custody of this child?_____

How often does the other parent see the child? __Weekly or more often; __Once a month; __Few times a year; __Never

How often does the child see grandparents? __Weekly or more; __Once or twice a month; __Few times a year; __Never; __No grandparents living

Primary Caregivers:
Please provide the following information about the primary caregivers, if not given previously.

Name:_____Relationship to child:_____

Address:_____Occupation:_____

Contact Phone:_____Email:_____

Employer:_____How long with employer?_____

With whom does the child currently live? (List all names, ages & relationships):

How long in current living situation?

How does this child get along with each person in the home?_____

Check the activities in which this child often participates with family.
__Conversations __Movies __Television __Church__Games Meals __Sports __Trips

Who cares for this child when caregivers are gone?_____

How many hours per day is this child in a child-care setting?_____How many different people care for this child? (please explain)_____
_____

What do you enjoy most about this child?_____
_____
_____

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

Who mainly handles the discipline in the home?_____Do all caregivers agree on discipline?_____Describe discipline techniques_____

What goals do you have for this child?_____

Friendships: *Please indicate how this child relates to other children*

Has problems relating to or playing with other children. If yes, describe:_____

Fights with playmates Yes No _____
Prefers playing w/ younger children Yes No_____
Has difficulty making friends Yes No_____
Prefers to play alone Yes No_____
Are there children in the neighborhood with whom child can play Yes No_____
What roles does this child take in peer groups, games, etc (e.g. leader, aggressor, etc)?
_____
_____

Recreation/Interest: *What activities does this child enjoy?*
Sports:_____
Hobbies:_____
Other:_____

Has this child's interest in participating in these activities declined recently? Yes No

Behavior/Temperament*: Please indicate whether this child exhibits any of the following:*

Is easily overstimulated in play	Y N	Seems unhappy most of the time	Y N
Has short attention span	Y N	Withholds affection	Y N
Seems impulsive	Y N	Hides feelings	Y N
Lacks self-control	Y N	Overreact when faced w/ problems	Y N
Uncomfortable meeting new people	Y N	Has abnormal fears (Describe)	Y N

_____

What "*sets this child off*"?_____

What tends to work best to control behaviors/emotions?_____

Adaptive Skills: *Indicate whether this child has the following skills*

Dresses self	Y N	Bathes self	Y N
Buys gifts or presents for others	Y N	Helps with chores	Y N
Can get or find home if lost	Y N	Has good table manners	Y N
Says "please" & "thank you"	Y N	Tells time accurately	Y N

Does this child get an allowance Y N If yes, how is it spent?_____

Educational History:
Preschool: Does or did the child attend preschool? _____ At what age? _____
Any problems in preschool? _____If yes, describe_____

Does or did the child attend kindergarten?_____ Any problems in kindergarten?_____
If yes, describe_____

Elementary/High School
Has child changed schools for any reasons other than normal academic progression?___
If yes, when & why?_____
Has child been retained in a grade in school?____If yes, when & why?_____
Has skipped a grade in school? _____If yes, when & why?_____
Has difficulty reading?___If yes, describe_____
Gets poor grades?____Describe most recent report card results (highest & lowest grade on report card)_____
Has child been tested for special education?____If yes, when?_____
Currently placed in special education?_____If yes, when?_____

Has anyone in the child's family ever been in special education?_____
If yes, who and what type of class?_____

Likes or Dislikes going to school?

Is or has been absent from school frequently?____If yes, when & why?_____

If in high school, will child graduate?_____

Has child ever had any difficulty with the police?____If yes, explain (reason, age, probation, probation officer)_____

Chief Complaint:

__Very unhappy
__Irritable
__Temper Outbursts
__Withdrawn
__Daydreaming
__Fearful
__Clumsy
__Overactive
__Slow
__Short attention span
__Distractible
__Lacks initiative
__Undependable
__Peer conflict
__Phobic
__Impulsive
__Stubborn
__Disobedient
__Infantile
__Mean to others
__Destructive
__Trouble with the law
__Running away
__Self-mutilating
__Head banging
__Rocking
__Shy
__Strange behavior
__Strange thoughts
__Fire setting
__Stealing
__Lying
__Sexual trouble
__School Performance
__Truancy
__Bed Wetting
__Soiled pants
__Eating problems
__Sleeping problems
__Sickly
__Drug use
__Alcohol use
__Suicide talk

How long have these problems occurred?_____

Additional
comments:_____
_____
_____
_____
_____
_____
_____
_____