SPECTRUM
PSYCHOLOGICAL SERVICES

Solving Puzzles One Child at a Time.

**Child Developmental Profile**

Child's Name: _____ Birthdate: _____ Age: _____ Grade: _____

Person(s) completing this form: _____ Today's date: _____

Relationship to Child: _____

Please describe briefly your current concerns about your child that brought you here today.____

_____

_____

_____

_____

How long have you had these concerns? _____

On the following scale, please check the severity of the problem:

❑mildly upsetting ❑moderately upsetting ❑very severe ❑extremely severe ❑totally incapacitating

Mother's name: _____ Birthdate: _____ Education: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone:_____ Email: _____

Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

Father's name: _____ Birthdate: _____ Education: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone:_____ Email: _____

Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

Custodian/guardian is: _____

*(if applicable)*

Stepparent's name: _____ Birthdate: _____ Education: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone:_____ Email: _____

Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

Please list all of the people who currently live with your child:
Name _____ Relationship to your child _____ Age _____
Name _____ Relationship to your child _____ Age _____
Name _____ Relationship to your child _____ Age _____
Name _____ Relationship to your child _____ Age _____
Name _____ Relationship to your child _____ Age _____

If any siblings are living outside of the home, please list their names and ages:
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

## DEVELOPMENT

Please fill in any information you have on the areas listed below.

### ***Pregnancy and Delivery***

How was the mother's health during pregnancy?_____

_____

_____

Mother's age when child was born? _____

Did the child's mother use any of the following substances or medications during pregnancy?

❑ Beer or wine (If yes, how often? _____)

❑ Coffee or other caffeine (coke, etc.) (If yes, how often? _____)

❑ Valium (Librium, Xanax)

❑ Tranquilizers

❑ Antiseizure medications

❑ Treatment for diabetes

❑ Antibiotics (for viral infections)

❑ Sleeping pills

❑ Other (please specify:_____)

Did your child's mother have toxemia or eclampsia? ❑ Yes ❑ No

Was there RH factor incompatibility? ❑ Yes ❑ No

Bedrest? ❑ Yes ❑ No

Why? _____

For How Long? _____ Any Drugs Given? _____

At how many weeks was your child born? _____

What was the duration of labor? _____

Was delivery: ❑Normal ❑Breech ❑Cesarean ❑Forceps Used ❑Induced

❑Pain meds used, if so what? _____

Were there any indications of fetal distress during labor or following birth?_____

_____

***First Few Months of Life***

Breast-fed? ❑ Yes ❑ No If so, for how long? _____

Does your child have any allergies? _____

_____

Were there any early infancy feeding problems? _____

_____

_____

Was your child colicky? ❑ Yes ❑ No

Were there any sleep patterns or problems? _____

_____

_____

Was your child an easy baby? Did he/she cry a lot? Did he/she follow a schedule fairly well?_

_____

_____

_____

How did your child behave with other children? _____

_____

_____

When he/she wanted something how insistent was he/she?_____

_____

_____

***Developmental Milestones***

At what age did your child do each of these?

Sit without support: _____ Crawl: _____

Walk without holding on: _____ Help when being dressed: _____

Tie shoelaces: _____ Button buttons: _____

Eat with a fork: _____ Write letters: _____

Use scissors:_____ Stay dry all day: _____

Stay dry all night: _____ Didn't soil his or her pants: _____

Speech/language development

Age when child said first word other than mama or dada: _____

Age when child said first word understandable to a stranger: _____

Age when child began using phrase speech (2-3 words): _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

_____

_____

Describe any early childhood care (babysitter, nursery school, mother, etc.) that your child has received. Please include the age in which your child received these services as well._____

_____

_____

_____

_____

**HEALTH**

My child's general health is:

- ❑ seems to be in good health
- ❑ overweight
- ❑ underweight
- ❑ overly active, always on the move
- ❑ tires easily, listless, lacks energy
- ❑ sleeps too much
- ❑ sleeps too little
- ❑ awkward in running, walking or playing

Please indicate any of the following illnesses or injuries your child has suffered from, and the ages at which they occurred, and any consequences of the illness or injury:

| | Age | Consequences | | Age | Consequences |
|---|---|---|---|---|---|
| ❑ mumps | | | ❑ high fevers | | |
| ❑ chicken pox | | | ❑ concussions | | |
| ❑ measles | | | ❑ fainting | | |
| ❑ whooping cough | | | ❑ allergies | | |
| ❑ scarlet fever | | | ❑ asthma | | |
| ❑ pneumonia | | | ❑ unconsciousness | | |
| ❑ encephalitis | | | ❑ tonsillectomy | | |
| ❑ otitis media | | | ❑ ear tubes | | |
| ❑ lead poisoning | | | ❑ hearing problems | | |

- ❑ seizures
- ❑ headaches
- ❑ heart problems
- ❑ hyperactivity
- ❑ broken bones
- ❑ head injury
- ❑ stomach pumped
- ❑ lost teeth
- ❑ vision problems
- ❑ stomach problems
- ❑ high blood pressure
- ❑ inattention
- ❑ severe lacerations
- ❑ severe bruises
- ❑ eye injury
- ❑ sutures

Please list all **current** medications your child is taking.

| Name of medication | Time child took last dosage | Dosage prescribed (mg/times/day) | Reason for medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list all **past** medications your child has been prescribed. _____
_____
_____
_____

**BEHAVIOR**

Please list any concerns you have about your child's behavior. _____
_____
_____
_____

How does your child get along with peers? _____
_____
_____

How does your child get along with siblings? _____
_____
_____

Are there any stressful events occurring in the family that may be affecting your child (e.g. separation, divorce, death, change in schools, money concerns, etc.)?_____
_____
_____
_____

To your knowledge, has your child ever been abused or neglected? _____
_____
_____

Is there anyone in the child's family (parents, grandparents, aunts, uncles, or siblings) that have ever had:

❑ Learning Difficulties _____
❑ Attention Problems _____
❑ Mental Retardation _____
❑ Autism/Aspergers _____
❑ Psychosis/Schizophrenia _____
❑ Depression _____
❑ Bipolar Disorder _____
❑ Anxiety Disorder _____
❑ Tics or Tourette's _____
❑ Alcohol Abuse _____
❑ Substance Abuse _____
❑ Antisocial Behavior _____
❑ Arrests _____
❑ Physical Abuse _____
❑ Sexual Abuse _____

Please list any **current** intervention your child is receiving (Speech, OT, PT, psychotherapy).

From To Description of treatment/Provider's name Diagnosis

_____
_____
_____

Please list any **past** treatment your child has received (Speech, OT, PT, psychotherapy).

From To Description of treatment/Provider's name Diagnosis

_____
_____
_____

Please list any past **evaluations** your child has had completed (Speech, OT, PT, Developmental, Psychological), and the provider's name.

_____
_____

**SCHOOLS/LEARNING**

| Please list all schools child has attended | Grade | Age | Concerns |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Does your child currently receive any special education services? _____
If so, what is your child's classification? _____
How often does your child receive services? _____
Has your child ever received any special services in the past? _____
Does (did) your child have any problems learning letters/numbers? _____

Does he/she confuse the sounds in words when speaking? _____
Can your child rhyme words?_____
Describe his/her handwriting. Is it a problem? _____
Can your child follow one step directions?_____
Two step directions? _____
Does your child appear to use vocabulary that is age appropriate? _____
Describe his/her oral expression (uses 1-2 words, phrase speech, full sentences) _____
_____

Does your child….

cuddle like other children? _____
look at you when you are talking or playing? _____
smile in response to a smile from others? _____
engage in reciprocal, back and forth play? _____
play simple imitation games, such as pat-a-cake or peek-a-boo? _____
show interest in other children? _____

point with his or her finger? _____
gesture (e.g. nod yes or no)? _____
direct your attention by holding up objects for you to see? _____
show things to people? _____
give inconsistent response to his or her name (or to commands)? _____
use rote, repetitive, or echolalic speech? _____
memorize strings of words or scripts? _____

have repetitive, stereotyped, or odd motor behavior? _____
have preoccupations or a narrow range of interests? _____
attend more to parts of an object (e.g. the wheels of a toy car)? _____
have limited or absent pretend play? _____
imitate other people's actions (e.g. wave bye-bye, play patty cake)? _____
play with toys in the same exact way every time? _____
appear strongly attached to a specific unusual object(s)? _____

Does your child seem sensitive to….

touch (tags, clothing, touch by others)? _____
noise (puts hands over ears, becomes very distracted)? _____
foods (textures, tastes, temperatures)? _____
smells (highly sensitive to faint smells or smells objects)? _____
movement (does not like swings, somersaults, etc)? _____
changes in routine (cannot transition, becomes upset)? _____
activity (tires easily, props self when playing/sitting)? _____

Please list your child's play interests, toy preferences, and any special talents. _____
_____
_____
_____

What things do you and your child enjoy doing together as a family? _____
_____
_____
_____

How do you let your child know when you are happy with his/her behavior? _____
_____
_____

How often is discipline used at home: ❑ frequently ❑ occasionally ❑ rarely

Discipline is administered by: ❑ mother ❑ father ❑ other

What type(s) of discipline are used: ❑ spanked ❑ loss of privileges ❑ restrictions
❑ isolation ❑ removal of rewards
❑ time-out ❑ talking ❑ rewards

Child's reaction to discipline: ❑ becomes angry ❑ cries ❑ withdraws
❑ sulks and pouts ❑ fights back

Effectiveness of discipline: ❑ behavior improves ❑ behavior remains the same
❑ behavior changes ❑ behavior worsens

**OTHER**

Please list any other information that you think is important with regard to your child. _____
_____
_____
_____

Name and contact info of your child's pediatrician/primary care doctor: _____
_____
_____
Would you like a copy of any assessment results sent to the doctor? _____

Please tell us who referred you to Spectrum Psychological Services _____
_____
_____

Do we have permission to thank the source for your referral? ❑ Yes ❑ No