Client Information & Developmental History

Date: _____

Child's name: _____ Age: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

Race/Ethnicity identity: _____ Handedness? Right Left

Person providing information:

Respondent's name and relationship to child: _____

Home phone: _____ Work phone: _____

Email: _____Is it ok to leave a message or email? No Yes

At what number: _____

Referral information:

Briefly describe your reason(s) for seeking help at this time? _____

_____

_____

Who referred you for this service? _____

Parent information:

Mother's name: _____ Stepmother? No Yes

Address: _____

Contact phone number: _____email:_____

Occupation: _____

Employer: _____ How long with present employer: _____

Highest grade completed: _____

Father's name: _____ Stepfather? No Yes

Address: _____

Contact phone number: _____ email:_____

Occupation: _____

Employer: _____ How long with present employer: _____

Highest grade completed: _____

Does the child have other parent(s)/stepparent(s)? No Yes If yes, name(s):_____ relationship _____ phone numbers: _____

Pregnancy/Birth

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

Was the child a planned pregnancy? Yes No If no, wanted? Yes No

At this child's birth what was the mother's age? _____ father's? _____

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

Number of previous pregnancies/miscarriages ____ Mom's age at 1st child's birth?_____

What number child is this born to his biological parents? Number_____ out of _____

Was this child born in a hospital? Yes No If no, where? _____

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

❑ Difficulty in conception	❑ Toxemia	❑ Abnormal weight gain
❑ Measles	❑ Excessive vomiting	❑ German Measles
❑ Excessive swelling	❑ Emotional Problems	❑ Vaginal Bleeding
❑ Flu	❑ Anemia	❑ High Blood Pressure

❑ Other (Rh incompatibility, etc.) _____

❑ Maternal injury? Describe: _____

❑ Hospitalization during pregnancy? Reason: _____

❑ X-rays during pregnancy? What month: _____

❑ Medications used during pregnancy? What kind: _____

❑ Alcohol used during pregnancy? Frequency? _____

❑ Cigarettes used during pregnancy? Frequency: _____

❑ Other drugs used during pregnancy:

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

Length of pregnancy: _____weeks Birth Weight: _____lbs_____oz
Length of labor: _____hours Apgar score: _____

Check any of the following complication that occurred during birth.

❑ Forceps used ❑ Breech birth ❑ Labor Induced ❑ Caesarean delivery
❑ other _____ ❑ Incubator: How long? _____
❑ Jaundiced: Bilirubin lights? No Yes If yes, 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? _____
Length of say in the 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 alone _____ Speak in sentences
_____ Walk up stairs

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

When was the child toilet trained? Days _____ Nights _____

Did bed-wetting occur after toilet training? No Yes If yes, until what age?_____

Did bed-soiling occur after toilet training? No Yes If yes, until what age?_____

Was there any medical reason for bed-wetting or soiling? No Yes If yes describe

_____

Circle any problems this child has experienced and describe on lines provided below

Walking Unclear speech Feeding Underweight problems Overweight problems
Colic Sleep problems Eating disorder Difficulties learning to ride a bike, skip, throw, catch

_____

_____

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

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

_____

_____

Medical History

Childhood illness/injuries such as: Measles, German measles, mumps, chicken pox, tuberculosis, whooping cough, scarlet fever, head injury (Coma or loss of consciousness), sustained high fever, Rheumatic fever, Diphtheria, Meningitis, Encephalitis, Anemia, Fever above 104, other serious illness or operations: Describe _____

_____

Has this child been on long-term medications (more than 6 months)? Yes No

If yes, when and what kind _____

Please circle if child has/had any of these medical problems:

Respiratory: frequent cold, chronic cough, asthma, hey fever, sinus condition

Cardiovascular: shortness of breath or dizziness with physical exertion, activity limitations due to heart condition, heart murmur

Gastrointestinal: excessive vomiting, frequent diarrhea, constipation, stomach pain

Genitourinary: urination in pant/bed, pain while urinating, excessive urination, strong urine odor

Musculosketal: muscle pain (describe), clumsy walk, poor posture, other muscle problem

Skin: frequent rashes, bruises easily, sores (describe) severe acne, itchy skin, eczema, etc

Neurological: seizures/convulsions, speech deficits, accident prone, bites nails, sucks thumb, grinds teeth, has tics/twitches, bangs head, rocks back and forth, bowel movements in pants/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 exam?_____

Vision: vision problems, wears glasses/contacts Most recent eye exam? _____

Please describe above circled issues here (e.g., when, how long, where in body, if treated, any complications, etc.)_____

_____

_____

_____

Have any of the child's family members had any of the following? If yes, please specify family member's relationship to this child.

Cancer _____	Muscular dystrophy _____	Speech or language problem_____
Cystic fibrosis _____	Parkinson's disease _____	Severe head injury_____
Diabetes _____	Sickle-cell anemia _____	Learning disability_____
Heart disease _____	Tay-Sachs disease _____	Food allergies_____
High blood pressure _____	Tourette's syndrome _____	Seizures or epilepsy _____
Kidney disease _____	Birth defect _____	Huntington's Chorea _____
Migraine headaches _____	Cerebral palsy _____	Hemophilia_____
Multiple sclerosis _____	Alcohol/drug abuse _____	Nervousness_____
Physical handicap _____	Behavior disorder _____	Stroke_____
Alzheimer's disease _____	Emotional disturbance_____	Mental retardation _____
Mental illness (specify) _____	Tuberculosis _____	Other: describe_____

_____

_____

Child's primary care physician _____ Phone _____

Address _____

How often does this child see the doctor? _____ Date of last visit? _____

Is the child currently on medication? Yes No
If yes, indicate type and reason _____

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

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

Has the child ever had a neurological exam Yes No If yes, neurologist's name _____

Reason for exam?_____ Has the child ever had a psychological or psychiatric evaluation? Yes No Do you have a copy of the results? Yes No

Family history:

Is this child closer to one parent (caregiver) than another? No Yes If yes, which?_____
Has this child ever experienced any parental separations, divorces, or death? No Yes
If yes, when? _____ How old was the child at the time _____ Please describe the circumstances _____
_____
_____
_____
If parents are separated or divorced, who has custody of this child? _____

How often does the other parent see this child? ❑ Weekly or more often
❑ Once a month ❑ Few times a year ❑ Never
How often does the child see grandparents? ❑ Weekly or more often
❑ Once or twice a month ❑ Few times a year ❑ Never ❑ No grandparents living

Home environment:

Please list all living arrangements this child has had (e.g., parents only, foster, kinship-care, residential treatment, group home, etc.) with approximate time child lived in each:
_____
_____
_____
_____
_____

Primary Caregivers:

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

Name: _____ Relationship to child_____

Address: _____

Contact phone number(s): _____ Occupation:_____

Employer: _____ How long with employer:____ Highest Grade?___

With whom does this child currently live? (list all names, ages, & relationship) _____
_____
_____
_____
_____
How long in current living situation? _____

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

❑ Apartment ❑ Single home ❑ other _____ How long at current address? _____

Check the activities in which this child often participates with the family
❑ Conversations ❑ Movies ❑ Television ❑ Church ❑ Games ❑ Meals ❑ Sport ❑ Trips
❑ Visits with relatives ❑ Homework help ❑ Other _____
If church, what religion and how involved is the family? _____

If primary caregiver works outside the home, please provide the following information
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 is mainly in charged of discipline in the home?_____ Do all caregivers agree on discipline?_____ Describe discipline techniques _____

_____

_____

_____

What would you like this child to be when he/she grows up? _____

What level of education do you hope this child will complete? ❑ High school ❑ Technical or vocational school ❑ College ❑ Law ❑ Medical ❑ other advanced studies

Friendships: *Please indicate how this child relates to other children*
Has problems relating to or playing with other children No Yes If yes, describe:

_____

_____

Fights with playmates No Yes _____
Prefers playing w/ younger children No Yes _____
Has difficulty making friends No Yes _____
Prefers to play alone No Yes _____
Are there children in the neighborhood with whom this child could play No Yes
What role does this child take in peer group games (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? No Yes

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

Is easily overstimulated in play	No	Yes	Seems unhappy most of the time	No	Yes
Has a short attention span	No	Yes	Withholds affection	No	Yes
Seems impulsive	No	Yes	Hides feelings	No	Yes
Seems overly energetic in play	No	Yes	Requires a lot of parent attention	No	Yes
Lacks self-control	No	Yes	Overreact when faced with prob.	No	Yes
Uncomfortable meeting new people	No	Yes	Has abnormal fears (describe)	No	Yes

_____

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	No	Yes	Bathes self	No	Yes
Buys gifts or presents for others	No	Yes	Helps with chores	No	Yes
Can get help or find home if lost	No	Yes	Has good table manners	No	Yes
Says "please" and "thank you"	No	Yes	Tells time accurately	No	Yes
Does this child get an allowance?	No	Yes	If yes, how is it spent? _____		

Educational History:

Preschool

Does or did the child attend preschool? No Yes At what age?_____

Amount of time per day _____ Days per week _____

Any problems in preschool? No Yes If yes, describe_____

_____

Does or did the child attend kindergarten? No Yes

Any problems in kindergarten No Yes If yes, describe _____

_____

Elementary/High School

Has child changed schools for reasons other than normal academic progression? No Yes

If yes, when and why? _____

Has been retained in a grade in school No Yes If yes when and why? _____

_____

Has skipped a grade in school No Yes If yes when and why? _____

_____

Has difficulty with reading No Yes If yes, describe? _____

_____

Has difficulty with math No Yes If yes, describe? _____

_____

Gets poor grades No Yes Describe most recent report card results (highest & lowest grade on report card) _____

Has child been tested for special education? No Yes If yes, when_____

Currently placed in special education? No Yes
If yes, what type of class? _____ Hours per day _____

Has anyone in the child's family ever been in special education? No Yes
If yes, who? _____ What type of class? _____

Dislikes going to school? No Yes

Is or has been absent from school frequently No Yes If yes, when and why?

_____

If in high school, when will this child graduate? _____

Do you have any concerns about the quality of this child's school or teachers? No Yes

If yes, describe _____

Has child ever had difficulty with the police? No Yes 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 these problems occurred _____
Additional comments _____

_____

_____

_____

_____

_____