CHILD DEVELOPMENTAL HISTORY FORM

Please take the time to complete this form carefully. All information will be treated confidentially.

Child's Name_____ **Age**_____ **Birth date**_____ **Sex**: **M☐ F☐**

Language(s) child speaks_____ Ethnicity_____

Family Structure

Parent/Guardian 1: Name_____Gender_____ Age_____ ☐Living with child ☐Not living with child

Education_____ Occupation_____ Employed currently? ☐Yes ☐No

Parent/Guardian 2: Name_____Gender_____ Age_____ ☐Living with child ☐Not living with child

Education_____ Occupation_____ Employed currently? ☐Yes ☐No

Parents are ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed ☐Other_____

If child is not living with parent(s), please explain circumstances:_____

"FAMILY" has many meanings. Who are the members of your child's family/household?

Name	Age	Relationship

Is there anything you would like us to be particularly sensitive to with regards to your child's family ?_____

_____

Pregnancy and Birth

Complications during pregnancy? _____ ☐ Full-term ☐ Premature

Child's weight at birth?_____lbs._____oz. Child's health at birth?_____

Problems?_____ Postpartum depression? ☐Yes ☐No

Adoption

Is your child adopted? ☐Yes At what age?_____ ☐ Domestic ☐International (Country:_____)

What were the circumstances of your child's adoption?_____

_____

_____

What have you told your child about his/her adoption?_____

_____

Does your child have any contact with birth parent(s)?_____

Parents Divorced/Living Apart

Does your child live in more than one household? Describe:_____

If you are divorced/separated, how old was your child when you separated?_____ Date of divorce_____

If divorced, what is the custody arrangement?_____

_____

Health History

Was your infant ☐Calm ☐Fussy ☐Colicky ☐Easily comforted ☐Hard to comfort? Describe:_____

Any difficulties with ☐Feeding ☐Sleeping ☐Bonding ☐Other?_____

Does your child have any health issues?_____

Does your child take any medication? (Give name/dose/frequency)_____

Has your child ever had a ☐Serious accident/illness?_____ ☐Hospitalization?_____

Did/does your child have ☐Recurrent ear infections? Have tubes in his/her ears? ☐Yes ☐No

☐Allergies? Describe:_____

☐Asthma? Treatment?_____

Has your child had a ☐HearingScreening ☐Vision Screening ☐Speech/Language Screening? When?_____

Developmental Milestones

As accurately as you can remember, how old was your child when s/he: Sat up _____ Crawled _____ Walked _____

Talked (2 words)_____Fed self (spoon)_____Weaned (bottle/breast)_____ Toilet trained: Started_____Completed_____

Do you have concerns about your child's development in *any* of these areas?

☐ Speech or Language ☐Motor Skills ☐Social Skills ☐Cognitive (Intellectual) ☐Sensory ☐Behavioral ☐Emotional

Describe:_____

Does your child have any developmental delays or special needs?_____

Has your child had a developmental or diagnostic assessment?_____

Does your child receive any special services (*i.e.: Speech, O.T., Behavior Therapy, etc.)*? _____

Family Changes and Loss History

Have any of the following changes occurred in your child's life? (Please give dates)

☐Separation/Divorce of parents	☐Parent's remarriage/new partner	☐Parent incarcerated
☐Death of a family member	☐Job loss/New job of parent	☐Death of a pet
☐Birth/Adoption of a sibling	☐Serious illness (child)	☐Move to a new home
☐Addiction of a family member	☐Serious illness (family member)	☐Separation from parent
☐Traumatic experience	☐Accident	☐Other_____

Describe:_____

How do you think this event impacted your child?_____

_____

Cultural History

Do you speak a second language in your home? ☐No ☐Yes What language(s)?_____

How well does your child speak this language?_____

Does your family celebrate rituals/traditions from a particular culture?_____

_____

Your Child's Daily Routine

What is the best time of day for you with your child?_____

Eating

Was/Is your child ☐bottle ☐breast fed? How long?_____

Does your child ☐use a pacifier ☐suck thumb ☐use a bottle? When?_____

Does your child ☐feed him/herself? ☐parent feeds child? _____

Food issues?_____

Food allergies?_____

Diapering/Toileting

What word does your child/family use for *urination?*_____*bowel movement?*_____

Is your child toilet trained? ☐Yes ☐No ☐ "In progress" Concerns?_____

Sleeping

Describe your child's sleeping arrangement:_____

Does your child go to sleep ☐easily ☐with difficulty ☐with a bottle ☐with a parent ☐use a "lovey" ☐ have a bedtime ritual?

Describe:_____

Does your child have a regular bedtime? ☐Yes ☐No Wakes at:_____Naps at:_____Goes to bed at:_____

Activities and Play

What are your child's favorite activities at home?_____

Where does your child usually play?_____

Does your child *avoid* any physical activities?_____

Does your child attend any regular groups or classes? ☐Yes ☐No
Describe:_____

Does your child demand a lot of adult attention? ☐Yes ☐No Describe:_____

Social Relationships

Who are the most important people in your child's life?_____

_____

Does your child usually play ☐alone ☐w/ siblings ☐w/peers ☐w/ younger children ☐w/older children ☐w/adults?

When are your child's opportunities to play with other children?_____

What adult does your child spend the most time with?_____

Day Care/Preschool/School

Is your child currently in childcare? When/Where?_____

Is your child currently in school? When/Where/What grade?_____

Your Child's Personality and Temperament

How does your child handle separation?_____

_____

What works best?_____

_____

One word that describes my child is…

"_____"

Is your child attached to any special objects?_____

Does your child have any fears?_____

How does your child express these fears?_____

What describes your child's "natural" temperament?

	(please circle)	
Energy	Quiet	x------x------x
Very active		
First Reaction (to new people, activities, ideas)	Outgoing, jumps right in	x------x------x
Shy, holds back		
Mood (general emotional tone)	Usually positive, happy	x------x------x
More serious, analytical		
Intensity (strength of emotional reactions)	Has mild reactions	x------x------x
Has strong reactions		
Persistence (ease of stopping when involved in an activity)	Easily redirected	x------x------x
"Locks in"		
Sensitivity (to noises, emotions, tastes, textures, stress)	Usually not sensitive	x------x------x
Very sensitive		
Perceptiveness (notices people, noises, objects)	Hardly ever notices	x------x------x
Very perceptive		
Adaptability (copes with transitions, changes in routine)	Flexible, adapts quickly	x------x------x
Adapts slowly		
Regularity (regular about eating,/sleeping times, etc.)	Regular, follows routine	x------x------x
Irregular		
Attention Span/Distractibility (ability to follow through with task)	Stays focused	x------x------x
	Easily distracted	x------x------x

Parenting Your Child

What has been your child's most "delightful" period?_____

What kind of discipline works best with your child?_____

What has been most difficult for you in parenting your child?_____

Parent Comments

What else should we know about your child or your family? (Include any concerns, developmental history, significant events, strengths, etc., that were not addressed above. Continue on separate page if necessary.)

Parent Signature_____ **Date**_____

Parent Signature_____ **Date**_____