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PSYCHIATRIC & ADDICTION services
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Child Developmental History Form

Child Information

Child's Name:	______		ID # (office use only)	______
Gender:	MALE	FEMALE	Date of Birth (mm/dd/yyyy):	______
Home Address:	______		Age (in years):	______
			Home Telephone Number:	______
Child's School:	______		Child's Grade Level:	______

Present Placement of Child

	Adults with Whom Child is Living	Non-residential Adults Involved with Child
Natural Mother:		
Natural Father:		
Step-Mother:		
Step-Father:		
Adoptive Mother:		
Adoptive Father:		
Foster Mother:		
Foster Father:		
Other (specify):		

Purpose of Appointment (provide a brief summary of main problems): ______

Pregnancy

Were there complications during the pregnancy with this child?	YES	NO
If YES, please describe: ______		
Did the mother of this child smoke during pregnancy?	YES	NO
Did the mother of this child drink during pregnancy?	YES	NO
Did the mother of this child use illegal substances during pregnancy?	YES	NO
Did the mother of this child take prescription medication during pregnancy?	YES	NO
If YES, please list medications: ______		

Delivery

What was the duration of pregnancy (in weeks):	______		
What was the duration of labor (in hours):	______		
Was the labor spontaneous?		YES	NO
Were forceps used during delivery of this child?		YES	NO
What was the type of delivery?	NORMAL	CAESAREAN	BREECH
Were there complications with the delivery of this child?		YES	NO
If YES, please describe: ______			

Client Name:______________________ ID #:____________________________

Child's Birth Weight (lbs. oz.) ________________

Post-Delivery Period

Were there any complications or problems with this child immediately following delivery?	YES	NO
If YES, please describe: ____________________		
Did this child have any birth defects?	YES	NO
If YES, please describe: ____________________		
Total number of days this child was in hospital following delivery:		

Infancy-Toddler Period

Were there any developmental or behavioral problems during this period?		YES	NO
If YES, please describe: ____________________			
Did this child have any problems meeting developmental milestones (i.e. crawling, sitting up, talking, etc.)?		YES	NO
If YES, please describe: ____________________			
How would you rate this child's coordination?	GOOD	AVERAGE	POOR

Peer Relationships

Does this child seek relationships with peers?	YES	NO
If NO, please describe: ____________________		
Does this child play primarily with children his/her own age?	YES	NO
If NO, are they older or younger (age difference)? ____________________		
Briefly describe any problems this child may have with peers: ____________________		

Medical History

Has this child suffered from any childhood diseases?		YES	NO
If YES, please describe: ____________________			
Has this child had any operations?		YES	NO
If YES, please describe: ____________________			
Has this child had any hospitalizations for illness other than operations?		YES	NO
If YES, please describe: ____________________			
Has this child suffered any head injuries?		YES	NO
If YES, any unconsciousness?	YES (unconsciousness)	NO (no unconsciousness)	
Has this child suffered any convulsions?		YES	NO
If YES, any associated fevers?	YES (with fever)	NO (without fever)	
Has this child ever had severe reactions to any immunizations or medications?		YES	NO
If YES, please describe: ____________________			
Has this child ever suffered from Meningitis or Encephalitis?		YES	NO
Has this child ever been in a Coma?		YES	NO
Has this child had eye problems?		YES	NO
If YES, please describe: ____________________			
Has this child had ear problems?		YES	NO
If YES, please describe: ____________________			

Client Name:______________________ ID #:____________________________

Has this child ever suffered from poisoning? YES NO

If YES, please describe: ______________________________

Has this child ever suffered physical, emotional or sexual abuse? YES NO

If YES, please describe: ______________________________

Present Medical Status

Is the child currently being treated for any medical conditions? YES NO

If YES, please describe and list any/all physicians? ______________________________

Family History – Mother

Age at pregnancy with this child: ______________________________

Number of previous pregnancies: ______________________________

Number of miscarriages or stillbirths: ______________________________

Highest Education/Grade Completed: ______________________________

Describe any learning problems or grades repeated: ______________________________

Describe any behavioral problems in school: ______________________________

Describe any medical problems: ______________________________

Describe any substance abuse problems: ______________________________

Have any of the mother's blood relatives (not including patient or siblings) ever had similar problems to those of this child? YES NO

If yes, please describe: ______________________________

Is there any history of mental illness in the mother's family? YES NO

If YES, please describe: ______________________________

Family History – Father

Age at time during child's conception: ______________________________

Highest Education/Grade Completed: ______________________________

Describe any learning problems or grades repeated: ______________________________

Describe any behavioral problems in school: ______________________________

Describe any medical problems: ______________________________

Describe any substance abuse problems: ______________________________

Have any of the father's blood relatives (not including patient or siblings) ever had similar problems to those of this child? YES NO

If yes, please describe: ______________________________

Is there any history of mental illness in the father's family? YES NO

If YES, please describe: ______________________________