

DEVELOPMENTAL HISTORY

Mid-State Health Center Psychology

Please Print

Name of Child _____ DOB _____ Age _____ Grade _____

Name of Mother _____ DOB _____ Age _____

Marital Status _____ Education _____ Occupation _____

Name of Father _____ DOB _____ Age _____

Marital Status _____ Education _____ Occupation _____

Siblings:

	<u>Name</u>	<u>DOB</u>	<u>Age</u>	<u>Education</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Others Living With Family:

	<u>Name</u>	<u>DOB</u>	<u>Age</u>	<u>Education</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

How Many Times has the child moved? _____

Pregnancy and Birth:

1. a) During this pregnancy did the mother experience any unusual illness, condition or accident such as German measles, RH incompatibility, false labor, etc.? If so, please describe:

b) Was the mother taking any drugs during pregnancy? If yes, please list: _____

2. Length of Pregnancy _____ Duration of labor: _____ Birth Weight: _____

Were there any problems with delivery such as breech birth, Caesarian section, etc? If so please describe:

3. Was the pregnancy planned? _____

Feeding:

Were there any feeding problems? If yes, please describe: _____

Developmental:

At what age did the following occur:

Age of walking _____ Age of talking _____

Age of toilet training _____ Dressed and undressed self _____

Describe infant's temperament: _____

Did the child have difficulty with strangers or separating from parents? _____

Were there any developmental problems or concerns? If yes, please explain: _____

Medical History:

Describe accidents or operations the child has had: _____

Describe any hospitalizations: _____

Were there any medical problems other than normal childhood illnesses? If yes, please explain:

Were any of these illnesses followed by noticeable changes in the child's general behavior or in his/her speech?

If so, please describe: _____

Have the child's eyes been examined? _____ Results: _____

Have the child's ears been examined? _____ Results: _____

Is the child under the care of a doctor? _____ Does he/she presently take medication? _____

Names of medications and dosages: _____

How long has the child taken the medications? _____

What was the child's reaction? _____

Child's Physician: _____ Address: _____

Has your child had any psychological testing? _____ When and where? _____

For what reason? _____

Has your child had a neurological examination? _____ When and where? _____

For what reason? _____

Education History:

Did the child attend Nursery School? _____ Kindergarten? _____

School Attending: _____ Grade: _____ Teacher: _____

What are his/her usual grades in the following subjects?

Math: _____ Reading: _____ Spelling: _____

Grades Failed? _____ Grades Skipped? _____

Is the child frequently absent from school? _____ If yes please explain: _____

Does the child have an Individual Education Plan, or is he/she coded? _____

Daily Behavior:

Does your child have nightmares? _____ Does he/she have fears? _____

Does your child sleep well? _____ Eat well? _____

Does he/she tend to play alone or with other children? _____

How does he/she get along with adults? _____

Is it difficult to discipline the child? _____ (Explain as fully as possible) _____

Would you describe the child as basically happy or unhappy? _____

Does your child have difficulty in concentration? _____

What are his/her favorite play activities? _____

Addition comments on behavior: _____

Describe relationship with mother, father, and siblings: _____

Name of Guardian: _____ Telephone #: _____

Name of Person Completing this Form: _____