West Island Therapy Centre | Le centre de thérapie West Island

Child's Developmental History:

Date (dd/mm/yr):_____

Child's Name:_____Date of birth(dd/mm/yr): _____
Male/Female: _____Age:_____

School:_____ Grade:_____

Were any grades skipped? Yes No
Were any grades repeated? Yes No Which ones?_____

Form completed by:_____ Date_____
(name and relationship to client)

Address: _____

City: _____

Prov, Postal Code: _____

Home phone:_____

Father's Name_____ Age:____ Occupation:_____
cell:_____ e-mail: _____

Mother's Name_____ Age:____ Occupation: _____
cell:_____ e-mail: _____

Marital status of parents: _____

Is the child adopted? Yes No. If so, at what age? _____from which country _____

Other children in the home:

Name: _____ Age: _____

Name:_____ Age: _____

Name:_____ Age: _____

Emergency Contact Person:_____

Emergency Contact Phone Number:_____

Relationship to child:_____

Who else lives in the home? (Please include name, relationship to the child)
_____
_____
_____

Are there close family members not living in the home? Yes No (Biological / step parents or siblings; list name, relationship to the child, age of brother/s sisters or other children)
_____
_____
_____

PREGNANCY HISTORY - Mother

While pregnant with this child was the mother under a doctor's care? Yes No

Mother's health during pregnancy: _____ Good _____ Fair _____ Poor

If fair or poor, please describe:_____
_____

During the pregnancy were there any complications (i.e. bleeding, emotional stress, high blood pressure, fetal distress)?
_____
_____
_____

Length of pregnancy:_____ Birth weight:_____ Apgar Score: (Scale from 1-10)
_____ Duration of labour:_____ Were forceps used? Yes No
Delivery was (check one) _____ Normal _____Breech _____ Caesarean

Were there any problems before or after delivery? Yes No If so, please describe:_____
_____

DEVELOPMENTAL HISTORY:

As you can remember, were there any delays in the following areas?

Held head up:_____
Smiled:_____
Rolled over:_____
Crawled:_____
Sat alone:_____

Stood alone:_____
Walked unassisted:_____
Said words:_____
Fed self:_____
Buttoned clothes:_____
Toilet Trained:_____
Dressed alone:_____
Said alphabet:_____
Named colors:_____
Used sentences:_____
Began to read:_____
Tied shoes:_____
Rode bike:_____

Any feeding or eating problems? Explain:
_____
_____

Bottle-fed or Breast-fed :_____ Weaned at what age?_____

Any speech or language delays? Explain:
_____
_____

Any problems with toilet training? Explain:
_____
_____

List and describe any sleep problems (difficulty falling asleep; staying or returning asleep, nightmares) at the present time or in the past?
_____
_____
_____

Is there a history of the following? What age?

____ Blank spells _____ Risk-taking behavior ____ Rocking behavior
_____ Falling spells _____ Impulsive behavior ____ Head bumping
____ Fainting spells _____ Unusual fears _____ Temper tantrums

FAMILY HISTORY:

Is there anyone in the extended or immediate family who has similar symptoms or problems as the child? Yes No
Please specify:_____

Is there a family history of substance abuse in your family? Yes No
Please specify:_____

Name and describe those family members (immediate and extended) who have a history of behavior, learning, drugs/alcohol and/or psychiatric problems (depression, highs and lows, hyperactivity, major mental illness):

_____
_____
_____
_____
_____

MEDICAL HISTORY:

Name of child's pediatrician: _____Phone number:_____

Comprehensive hearing test:
_____No
_____Yes Date Completed: _____ Results:_____

Visual Exam:
_____No
_____Yes Date Completed: _____ Results:_____

Is your child on any prescribed or over the counter mediations? Yes No
If so, what is the medicine, the dosage and how long has your child been on it?_____
_____
_____

List and explain your child's current or past medical or neurological problems. Include head injuries, seizures, heart problems, disabilities, asthma etc.

_____
_____
_____

Has your child ever been hospitalized: Yes No
If so, when and why?_____

Last Physical:_____ Child height:_____ Weight:_____

Has your child received any previous counseling or mental health treatment? Please list and describe all past psychiatric and counseling situations both inpatient and outpatient:

_____
_____
_____

Is there any history of abuse (emotional, physical, sexual)? Explain:

_____
_____
_____

Is there a history of, or current concern with any of the following (please check). For each item checked, please list how long these have been problems.

_____ School behavior problems
_____ Eating problems
_____ Speech Difficulties
_____ Head injuries/concussions
_____ Bullying
_____ Stealing
_____ Aggressive behaviour
_____ Lying
_____ Avoids cuddling
_____ Sleep difficulties
_____ Nightmares
_____ Headaches
_____ High energy
_____ Low energy
_____ Constipation
_____ Inappropriate play with other children
_____ Aggressive behavior
_____ Legal problems
_____ Poor memory
_____ Wetting pants
_____ Soiling pants
_____ Panic attacks
_____ Fears
_____ Attention problems
_____ Bizarre behaviors
_____ Temper tantrums
_____ Crying spells
_____ Cruelty to animals
_____ Truancy
_____ Impulsivity
_____ Fire setting
_____ Defiance to authority
_____ Obsessive behavior
_____ Suicidal thoughts
_____ Hallucinations
_____ Other

What concerns or issues convinced you to seek assistance now?

_____
_____
_____

The problem has been going on for how long? (weeks, months, one year, two years or longer)

_____
_____
_____

My child has the following problems at home (i.e. aggressive behavior, sad mood, anxiety, risk taking behavior, bedwetting, etc). Please list and describe:

_____
_____
_____

My child has the following problems at school (i.e. learning, behavior, peer problems, etc). Please list and describe:

_____
_____
_____

My child has the following problems in other situations:

_____
_____
_____

My child has had the following problems (behavior, learning, emotional) in the past:

_____
_____
_____

What treatment has been received for these problems?

_____
_____
_____

Current or past stressors that may be contributing to my child's problems are the following (i.e. marital conflict or divorce, abuse, death in the family, etc):

_____
_____
_____

To your knowledge has your child tried any of the following?

Tobacco: yes no
Alcohol: yes no
Drugs: yes no

How does your child get along with other children?

(Please circle) Good Fair Poor

_____
_____

Do you have any concerns about their friends? Yes No

_____
_____

What does your child and family do for fun?: (Please Check)

Games:____ Outing:____ Movies:____ Sports:____ Arts_____ School Functions:_____ Other:

What are your child's strengths and affinities? (Please Check)?

Academics:_____ Music:_____ Art:_____ Sports:_____
Helpful:_____ Good-natured:_____ Plays well with others:_____
Cooperative:_____ Other:_____

Is there anything else I should know that doesn't appear on this or other forms but that is or might be important?

_____
_____
_____
_____
_____

Records to bring to your consultation:

1. Your child's report card form the past two years
2. Your child's most recent Individual Education Plan (IEP) if applicable
3. Copies of any previous reports from psychologists, speech therapists, occupational therapists, school or pediatrician

Please bring this completed form to your first consultation with your psychologist/therapist.

Thank you.