



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: _____

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

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 from 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.