CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

Date: ________________________ Name of Child: ____

Date of Birth: ________________ Age: _____________

Name of person completing this form: ____

Relationship to Child: ____

PRESENTING PROBLEM:
Describe the problems your child is having and when they started:

PREGNANCY AND BIRTH HISTORY:
Was the pregnancy _____planned or _____unplanned? Was it full-term? ____Yes ____No

How did the mother feel about this pregnancy?

How did the father feel about this pregnancy?

Was any alcohol, drugs, or medications used during pregnancy? ____Yes ____No
If yes, please describe:

Did either parent smoke during the pregnancy? ____Yes ____No If yes, who? ________________________

Were there any problems with the pregnancy or birth?

DEVELOPMENT:
Was the baby _____breast fed _____ bottle fed _____both

Who was the primary caretaker for the child? ____

Estimate when your child first:

Smiled	_______	Rolled over	_______	Sat up on own	_______
Crawled	_______	Stood	_______	Walked	_______
Ran	_______	Said first word	_______	Said phrases	_______
Fed self	_______	Dressed self	_______	Toilet trained	_______

Were there any behavioral difficulties or discipline problems during early childhood?

Did your child have temper tantrums? _____Yes _____No If yes, please describe:

What discipline techniques were used? Describe the impact.

EDUCATION:
What grade is your child in? _______ Has she/he ever repeated or skipped a grade? Which one? _______

Does your child have any attendance problems?

Has she/he had any discipline problems at school? Has she/he ever been suspended or expelled?

What are her/his grades like? Have her/his grades changed recently?

Does she/he have any learning disabilities, attend special education classes, or require any special accommodations?

Does she/he have any hearing, vision, or speech impairments?

Do you have any concerns about how your child gets along with his/her peers in the school setting? If yes, describe.

Healthy Mind Counseling Services, Inc.

MEDICAL HISTORY:

What is the name of your child's current physician (PCP)? ____

Address: ____ Phone: _______________________

Date of Last Appointment: _____________ Are screenings/immunizations up to date: ☐ Yes ☐ No

May we contact your child's PCP in order to coordinate care? ____Yes ____No

Release of Information Signed: ☐ *Yes* ☐ *No* *If no, indicate reason:* _________________________________ *(for office use only)*

Date other treatment provider was contacted: ____ *(for office use only)*

Please check if your child has had any of the following (and if so, at what age):

____Seizures ____High fevers ____Measles ____Mumps

____Chicken Pox ____Whooping Cough ____Diphtheria ____Croup

____Pneumonia ____Tonsillitis ____Meningitis ____Encephalitis

____Rheumatic Fever ____Tuberculosis ____Sinusitis ____Chronic colds

____Enlarged glands ____Thyroid problems ____Asthma ____Chronic ear infections

____Heart trouble ____Head trauma ____Allergies (please describe):________________

List any other illnesses (including chronic illnesses or infectious diseases), accidents, injuries, hospitalizations, and surgeries:

List all prescription and over-the counter medications your child takes for any medical reason (include any vitamins & herbal supplements):

List any family history of physical illnesses or chronic medical conditions:

TREATMENT HISTORY:

Is your child currently seeing another Psychiatrist, Psychologist, Social Worker, or Counselor? ____Yes ____No

What is the name of your child's other treatment provider? ____

Address: ____ Phone: _______________________

May we contact your child's other treatment provider in order to coordinate care? ____Yes ____No

Release of Information Signed: ☐ *Yes* ☐ *No* *If no, indicate reason:* _________________________________ *(for office use only)*

Date other treatment provider was contacted: ____ *(for office use only)*

Has your child been in counseling before? If yes, please list who they saw, when they were seen, how long counseling lasted, and the outcome.

Has your child ever been hospitalized for emotional problems or for alcohol/drug treatment? If yes, please list when they were seen, where they were hospitalized, and the outcome:

List any medications your child **currently takes** for emotional or behavioral problems:

List any medications your child has taken **in the past** for emotional or behavioral problems:

Does your child, **if age 16 or older**, have a psychiatric advanced directive? Yes No N/A
If yes, explain and provide paperwork:

List any community resources you or your family has utilized (e.g., support groups, social services, AA/NA, school-based services):

SOCIAL HISTORY:

Does your child make friends easily? How does she/he get along with others?

Have there been any losses, changes, or transitions in your child's life?

Does the family have any cultural, spiritual, or religious beliefs that influence the child?

What hobbies/interests does your child have (include extra curricular activities)?

What are your child's strengths? What does she/he believe are strengths?

FAMILY HISTORY:
Are the parents of the child married, separated, or divorced? If they are separated or divorced, what are the custody arrangements? Have there been any problems with the custody arrangements?

Please list all members of the household, their ages, and their relationship to your child:

Is there a history of mental illness, suicide attempts, or substance abuse in your family? If yes, please explain.

Is there any additional information you feel would be helpful to the treatment of your child?

What are your goals and expectations for treatment?