

FAMILY PSYCHOLOGY ASSOCIATES, PC

CHILD SOCIAL & DEVELOPMENTAL HISTORY

Instructions: Please complete the following about your child and family. If any questions do not apply to your child, simply write "DNA" (does not apply) in the space provided or leave the space blank. It is best if this form is completed by all parents or primary caretakers. This information will be helpful to your child's doctor or other professionals to better understand your child and your family.

Child's name: _____ Age: _____ DOB: _____ Sex: _____

Address: _____ City: _____ Zip: _____

School: _____ Grade: _____ School Phone: _____

If your child is in child care, name and number of your child care provider: _____

Child's School: _____ Grade: _____ In 504 plan? (yes) (no)

Special Educational Services: (e.g., Chapter 1, Resource Room, Tutoring) _____

Has the school or AEA evaluated child? (yes) (no) if yes — when? _____

Results: _____

Current Teachers: _____

Church affiliation: _____ Social involvement: _____

Informant's name and relationship to child: _____

FAMILY COMPOSITION: *Parent/Step-Parent/Guardian Information*

Parent: _____ Address: _____

City: _____ Zip: _____ Hm# _____ Cell: _____ Wk# _____

Emp: _____ Days/Hours: _____ Highest Grade / Degree Completed: _____

Is this child your ___ Biological child, ___ Adopted child or ___ Foster child? ___ Other? _____

Parent: _____ Address: _____

City: _____ Zip: _____ Hm# _____ Cell: _____ Wk# _____

Emp: _____ Days/Hours: _____ Highest Grade / Degree Completed: _____

Is this child your: ___ Biological child, ___ Adopted child or ___ Foster child? ___ Other? _____

With whom does this child live? _____

Who has legal custody of this child? _____

Other persons living in child's home:

NAME	BIRTH DATE	AGE	EDUCATION

CURRENT CONCERNS:

BEHAVIOR CHARACTERISTICS: *check all that CURRENTLY apply to your child.*

Overactive/Fidgety Inattentive Under-active Moody Plays well

Accident prone	Stubborn	Temper	Leader
Tantrums	Shy	Easily afraid	Cooperative
Excitable	Impulsive	Easily angered	Has a conscience
Sad/Unhappy	Nervous/Worried	Follower	Happy/Cheerful
Loner	Mean to animals	Lying	Cheating
Fire setting	Moody	Rebellious	Age appropriate playmates
Stealing	Thumb sucking	Nail biting	Cries easily
Mean to children	Stealing	Tics/Nervous habits	Sensitive
Destructive			

What are you most concerned about regarding your child that has led you to complete this history form?

Has there been a recent crisis or loss in your child's life? Explain: _____

DEVELOPMENT AND MEDICAL INFORMATION:

Smoking during pregnancy? _____ # Cigarettes smoked per day: _____

Alcohol consumption during pregnancy: _____ other drug use during pregnancy? _____

Delivery:

Type of Labor: Spontaneous Induced Duration (hours **Delivery:** Normal Breech Caesarean
Complications: Cord around neck Hemorrhage Infant injured during delivery Other: _____
 Birth weight: _____ lbs. _____ oz.

Post Delivery Period:

Normal Premature Low Birth Weight Received Oxygen Meningitis Paralysis Floppiness
 Low Blood Sugar Blood Transfusion Seizures Jaundice Cyanosis (blue) Incubator Care
 Infection (specify) _____ Other _____

Infancy-Toddler Period: Were any of the following present to a significant degree during the first few years of life?

Not enjoy cuddling Not calmed by being held or stroked Colic Diminished sleep Difficult to comfort
 Excessive restlessness Excessively Irritable Frequent head banging Difficulty nursing /bottle
 Difficulty adjusting to regular food Age completed toilet training _____

Comments: _____

Milestones: At what age did your child: _____ sit alone _____ crawl _____ walk without support _____ speak single words

Medical History: Child's Physician: _____ phone: _____

Date of last doctor visit: _____ reason for visit: _____

Child's general health is: excellent good fair poor
 Has your child: _____ Comments: _____

- Has serious illness since birth? (yes) (no) _____
- Been hospitalized since birth? (yes) (no) _____
- Had convulsions / seizures? (yes) (no) _____
- Had high fever? (yes) (no) _____
- Ever lost consciousness? (yes) (no) _____
- Had an EEG, MRI, CT scan, EKG? (yes) (no) _____

7. Had ear infections? (yes) (no) _____
8. Had treatment for ear infections with tubes? (yes) (no) _____
9. Had a hearing evaluation? (yes) (no) _____
10. Had a vision evaluation? (yes) (no) _____
11. Any allergies? (yes) (no) _____
12. Have a genetic condition? (yes) (no) _____
13. Have a chronic health problem? (yes) (no) _____
14. Is your child currently taking medication? (yes) (no) _____
15. Are your child's immunizations current? (yes) (no) _____

Present illnesses for which the child is being treated: _____

Psychotropic medications (stimulants, medications for ADHD, mood, anxiety medications) child has been taking or is currently taking. Include name of medication and dosing. Current medications: _____

Previous medications: _____

Describe any benefit from these medications or adverse effects: _____

Has your child ever received treatment by a mental health professional? If so, who provided this treatment, when, and what was the purpose of the treatment? _____

FAMILY INFORMATION & HISTORY:

Use the checklists below to describe any family history of psychiatric and learning problems. (in child's parents, grandparents, or siblings)

Aggressiveness / Defiance: (specify who) _____

Difficulties with attention / Hyperactivity as a child: (specify who) _____

Learning problems: (specify who) _____

Failed to graduate from high school: (specify who) _____

Intellectual Disability: (specify who) _____

Psychosis or Schizophrenia: (specify who) _____

Depression: (specify who) _____

Tics or Tourette's syndrome: (specify who) _____

Alcohol abuse / Substance abuse: (specify who) _____

Arrests: (specify who) _____

Physical abuse / Sexual abuse: (specify who) _____

Nervous tension problem/anxiety: (specify who) _____

Temper problems: (specify who) _____

Suicide attempts: (specify who) _____

Attention Deficit / Hyperactivity Disorder: (specify who) _____

Hearing loss: (specify who) _____

Vision problems: (specify who) _____

Genetic Disorder: (specify who) _____

Developmental delays: (specify who) _____

Seizure Disorder: (specify who) _____

Antisocial behavior: (specify who) _____

In general, describe your child's performance during elementary school. Go grade by grade, if necessary and list any outstanding strengths or problems.

Describe your child's performance during middle school and high school. Again, go grade by grade, if necessary, and list any outstanding strengths or problems. _____

Has your child ever repeated a grade? If so, which grade? _____ Comments: _____

Indicate if your child's teacher(s) describes any of the following as significant classroom problems.

- | | |
|---|---|
| ☐ Doesn't sit still in seat | ☐ Frequently gets up and walks around the classroom |
| ☐ Shouts out | ☐ Does not wait their turn to be called on |
| ☐ Does not cooperate well in group activities | ☐ Typically does better in a one to one relationship |
| ☐ Does not respect the rights of others | ☐ Does not pay attention during lessons |
| ☐ Fails to finish assigned home work | ☐ Bullies other children |
| ☐ Wets/soils self | ☐ Difficulty transitioning |
| ☐ Is not sought out by others to play or work together | |

Describe any problems your child may have in school with learning: _____

Describe any problems your child may have with homework: (e.g. forgets, does not return it to school, etc.) _____

CHILD MANAGEMENT TECHNIQUES

Describe any differences or similarities between each of the parent's management style in handling disruptive behavior: _____

Describe what steps you might take to improve your management style in handling disruptive behavior: _____

STRENGTHS AND ACCOMPLISHMENTS

We realize that we have focused largely on problems that your child may be having. However, we are also quite interested in understanding your child's strengths, talents, skills and accomplishments. Please use the space below to describe these assets and use additional pages if necessary.
