CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

Client Name: _______________ ID# ___________ Date: ______________

NEO-NATAL THROUGH EARLY CHILDHOOD DEVELOPMENT

1. During pregnancy, was mother on medication? □ Yes □ No
   If yes, what kind? _____________________________________________

2. During pregnancy, did mother smoke? □ Yes □ No
   If yes, how many cigarettes each day? ___________________________

3. During pregnancy, did mother drink alcoholic beverages? □ Yes □ No
   If yes, what did she drink? ____________________________________

4. Approximately how much alcohol was consumed each day? __________

5. During pregnancy, did mother use drugs? □ Yes □ No
   If yes, what kind? ____________________________________________

6. Were there any pregnancy complications? □ Yes □ No
   If yes, please explain: ________________________________________

7. Were forceps used during delivery? □ Yes □ No

8. Was a Cesarean section performed? □ Yes □ No
   If yes, for what reason? _______________________________________

9. Was the child premature? □ Yes □ No
   If so, by how many months? ___________________________________

10. What was the child’s birth weight? _____________________________

11. Were there any birth defects or complications? □ Yes □ No
    If yes, please describe: _______________________________________

12. Were there any feeding problems? □ Yes □ No
    If yes, please describe: _______________________________________

13. Were there any sleeping problems? □ Yes □ No
    If yes, please describe: _______________________________________

14. As an infant, was the child even tempered? □ Yes □ No

15. As an infant, did the child seem to cry excessively? □ Yes □ No
16. As an infant, did the child like to be held?  □ Yes □ No
17. As an infant, was the child alert?  □ Yes □ No
18. Were there any special problems in growth and development during the first few years?  □ Yes □ No
   If yes, please describe: ____________________________________________________________
19. Have there been any special problems with speech or language functioning?  □ Yes □ No
   If yes, please describe: ____________________________________________________________
20. Have there been any special problems with visual functioning?  □ Yes □ No
   If yes, please describe: ____________________________________________________________
21. Have there been any special problems with hearing functioning?  □ Yes □ No
   If yes, please describe: ____________________________________________________________

**DEVELOPMENTAL MILESTONES**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Age</th>
<th>Behavior</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showed response to mother</td>
<td></td>
<td>Put several words together</td>
<td></td>
</tr>
<tr>
<td>Rolled over</td>
<td></td>
<td>Dressed self</td>
<td></td>
</tr>
<tr>
<td>Sat alone</td>
<td></td>
<td>Became toilet trained</td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td></td>
<td>Stayed dry at night</td>
<td></td>
</tr>
<tr>
<td>Walked alone</td>
<td></td>
<td>Fed self</td>
<td></td>
</tr>
<tr>
<td>Babbled</td>
<td></td>
<td>Rode tricycle</td>
<td></td>
</tr>
<tr>
<td>Spoke first word</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY**

Place a check next to any illness or condition that your child has had. When you check an item also note the approximate age of the illness.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Date or Age</th>
<th>Illness</th>
<th>Date or Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Measles</td>
<td></td>
<td>☐ Dizziness</td>
<td></td>
</tr>
<tr>
<td>☐ German measles</td>
<td></td>
<td>☐ Frequent/severe headaches</td>
<td></td>
</tr>
<tr>
<td>☐ Mumps</td>
<td></td>
<td>☐ Difficulty concentrating</td>
<td></td>
</tr>
<tr>
<td>☐ Chicken pox</td>
<td></td>
<td>☐ Memory problems</td>
<td></td>
</tr>
<tr>
<td>☐ Whooping cough</td>
<td></td>
<td>☐ Extreme tiredness/weakness</td>
<td></td>
</tr>
</tbody>
</table>
Please provide any relevant details: ___________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Are your child’s immunizations up to date?  ☐ Yes ☐ No  If no, state reason: __________________________
_________________________________________________________________________________
_________________________________________________________________________________

EDUCATIONAL HISTORY/INTELLECTUAL FUNCTIONING
1. **What grade is your child in at school?** __________________________
   (If school is not in session, please indicate highest grade completed).

2. **Does your child have:**
   - ☐ Difficulty with reading                    ☐ Difficulty with arithmetic
   - ☐ Difficulty with spelling                  ☐ Difficulty with writing
   - ☐ Difficulty with other subjects (please list):
     __________________________________________
     __________________________________________

3. **Is your child in a special education class?** ☐ Yes ☐ No
4. **Has your child been held back in a grade?**
   - Yes
   - No
   If yes, what grade and why? ____________________________________________

5. **Has your child ever received special tutoring or counseling in school?**
   - Yes
   - No
   If yes, please describe: ____________________________________________

Signature of person completing form and relationship to client

Date

This form has been reviewed and discussed with the person completing the form:

Signature of staff member

Date