DEVELOPMENTAL HISTORY

Mid-State Health Center Psychology

Please Print

Name of Child _____ DOB _____ Age _____ Grade _____

Name of Mother _____ DOB _____ Age _____

Marital Status _____ Education _____ Occupation _____

Name of Father _____ DOB _____ Age _____

Marital Status _____ Education _____ Occupation _____

Siblings:

	Name	DOB	Age	Education
1.				
2.				
3.				
4.				

Others Living With Family:

	Name	DOB	Age	Education
1.				
2.				
3.				
4.				

How Many Times has the child moved? _____

Pregnancy and Birth:

1. a) During this pregnancy did the mother experience any unusual illness, condition or accident such as German measles, RH incompatibility, false labor, etc.? If so, please describe:

_____

b) Was the mother taking any drugs during pregnancy? If yes, please list: _____

_____

2. Length of Pregnancy _____ Duration of labor: _____ Birth Weight: _____

Were there any problems with delivery such as breech birth, Caesarian section, etc? If so please describe:

_____

3. Was the pregnancy planned? No _____

Feeding:

Were there any feeding problems? If yes, please describe: _____

_____

Developmental:

At what age did the following occur:

Age of walking _____ Age of talking _____

Age of toilet training _____ Dressed and undressed self _____

Describe infant's temperament: _____

Did the child have difficulty with strangers or separating from parents? _____

Were there any developmental problems or concerns? If yes, please explain: _____

_____

Medical History:

Describe accidents or operations the child has had: _____

_____

Describe any hospitalizations: _____

_____

Were there any medical problems other than normal childhood illnesses? If yes, please explain:

_____

Were any of these illnesses followed by noticeable changes in the child's general behavior or in his/her speech?

If so, please describe: _____

_____

Have the child's eyes been examined? No _____ Results: _____

Have the child's ears been examined? No _____ Results: _____

Is the child under the care of a doctor? No _____ Does he/she presently take medication? No _____

Names of medications and dosages: _____

How long has the child taken the medications? _____

What was the child's reaction? _____

Child's Physician: _____ Address: _____

Has your child had any psychological testing? No _____ When and where? _____

For what reason? _____

Has your child had a neurological examination? No _____ When and where? _____

For what reason? _____

Education History:

Did the child attend Nursery School? No _____ Kindergarten? _____

School Attending: _____ Grade: _____ Teacher: _____

What are his/her usual grades in the following subjects?

Math: _____ Reading: _____ Spelling: _____

Grades Failed? _____ Grades Skipped? _____

Is the child frequently absent from school? No _____ If yes please explain: _____

_____

Does the child have an Individual Education Plan, or is he/she coded? _____

Daily Behavior:

Does your child have nightmares? No

Does he/she have fears? No

Does your child sleep well? No

Eat well? No

Does he/she tend to play alone or with other children? With other children

How does he/she get along with adults? No

Is it difficult to discipline the child? No

(Explain as fully as possible)

Would you describe the child as basically happy or unhappy?

Does your child have difficulty in concentration?

What are his/her favorite play activities?

Addition comments on behavior:

Describe relationship with mother, father, and siblings:

Name of Guardian:

Telephone #:

Name of Person Completing this Form:

Print Form