WEISSGLASS PSYCHOLOGICAL SERVICES PLLC

Child/Adolescent Developmental History

Please complete this confidential form to help me better understand you and your child's concerns.

Child's Name: _____ Age: _____

Date of Birth: _____ Gender: _____

Current Grade: _____ Current School: _____

Family Information

Parent's marital status (check all):

- ☐ single, never married
- ☐ married
- ☐ separated; when:_____
- ☐ divorced; when:_____
- ☐ widowed; when:_____
- ☐ remarried; when: _____

Mother's current age: _____

Mother's current occupation: _____

Father's current age: _____

Father's current occupation: _____

Guardian's current age: _____

Guardian's current occupation: _____

Please check any of the following that are true for this child:

- ☐ was adopted If so, is child aware ☐ yes ☐ no
- ☐ is a foster child If so, since when _____

Who lives in home with child? (mother, father, stepparent, parent's significant other, brothers and sisters, aunts, uncles, grandparents, foster parents, etc.)

Name	Age	Relation to child

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Pregnancy History

Please check any of the following, which occurred during the mother's pregnancy with this child.

- ☐ did not receive prenatal care
- ☐ severe colds, flu
- ☐ German measles (rubella)
- ☐ bladder or kidney infection
- ☐ high blood pressure
- ☐ toxemia
- ☐ anemia (low iron)
- ☐ RH incompatibility
- ☐ Gained less than 10 lbs.
- ☐ Gained more than 40 lbs
- ☐ smoking cigarettes
- ☐ alcohol use
- ☐ prescription drug use type:_____
- ☐ other drug use type:_____
- ☐ physical injury/trauma
- ☐ depression, anxiety
- ☐ hospitalization during pregnancy
- ☐ surgery during pregnancy
- ☐ other _____
- ☐ other _____

Child's Birth and Postnatal History

Born: _____ weeks early ☐ on-time _____weeks late
Apgar Scores, if known _____

Birth and delivery:

- ☐ no complications
- ☐ caesarean section
- ☐ multiple births
- ☐ cord around neck
- ☐ forceps/vacuum assisted
- ☐ other _____

How much did baby weigh? _____
How long did baby stay in hospital? _____
Please check any of the following, which applied during the first month after birth:

- ☐ stay in intensive care nursery
- ☐ breathing problems
- ☐ jaundice (skin yellow
- ☐ cyanosis (skin blue)
- ☐ convulsions/seizures
- ☐ feeding problems
- ☐ injury
- ☐ surgery _____
- ☐ physical deformities
- ☐ given medications type: _____
- ☐ excessive crying
- ☐ sleeping problem
- ☐ very inactive
- ☐ very jittery
- ☐ other: _____

Developmental History

As closely as you can recall, please write the age when your child did the following:

_____	sat up without support	_____	used short sentences
_____	crawled	_____	toilet-trained (day)
_____	walked alone	_____	toilet-trained (night)
_____	gave up bottle/breast	_____	dressed him/herself
_____	spoke first word	_____	drew a circle

Child's Medical History

Please check any of the following that the child has had since birth.

- ☐ asthma
- ☐ recurrent ear infections/tubes
- ☐ meningitis &/or encephalitis
- ☐ headaches &/or migraines
- ☐ seizures
- ☐ head injuries &/or concussions
- ☐ allergies (type: _____
- ☐ eye and/or vision problems
- ☐ bowel problems
- ☐ slow weight gain
- ☐ German measles, whooping cough, measles, mumps, or chicken pox, scarlet fever
- ☐ diabetes (Type I, Type II)
- ☐ lead exposure
- ☐ infections (TB, CMV, HIV)
- ☐ genetic or chromosomal testing
- ☐ EEG, MRI, or CT
- ☐ serious injury: _____
- ☐ hospitalization: _____
- ☐ surgery: _____
- ☐ other: _____
- ☐ other: _____

What medication(s) has your child taken or is now taking?

Medication	Dates	Reason	Effectiveness

Prior Counseling/Treatment Information

Please fill in the following information, regarding past mental health services:

Therapy/Hospitalizations/Community Support	Dates (or ages)

Daycare/School Information

Please fill in the following information, including daycare:

School	Dates (or ages) attended

Has your child ever repeated a grade, been retained, or held back? ☐ yes ☐ no
If so, what grade(s)? _____

Check your child's current academic performance:
☐ Above grade level ☐ On grade level ☐ Below grade level ☐ Inconsistent

Describe academic difficulties:

_____

_____

Please check any of the following services that your child has ever received.

- ☐ special education/resource services
- ☐ self-contained classroom at school
- ☐ speech/language therapy (SP/L)
- ☐ occupational therapy (OT)
- ☐ physical therapy (PT)
- ☐ other: _____

Behavioral Patterns

Please check and/or circle any of the following that has **ever** been true of your child:

- ☐ Extremely restless/hyperactive
- ☐ Clingy/wants to be held too often
- ☐ Extreme reaction to tastes/being touched
- ☐ Difficulty being consoled/calmed
- ☐ Extreme reaction to noises
- ☐ Seems too sad/too happy
- ☐ Seems like a "worry-wart"
- ☐ Very irritable/moody
- ☐ Frequent/unpredictable angry outbursts
- ☐ Head banging/ hurts self
- ☐ Bedwetting/toileting accidents after 5
- ☐ Rocking of body
- ☐ Aggressive towards others
- ☐ Damages property
- ☐ Trouble making eye-contact
- ☐ Is not affectionate
- ☐ Making odd sounds, noises
- ☐ Will not play with other children
- ☐ Does not seem to pay attention
- ☐ Sexualized language or behavior
- ☐ Talks about suicide/wanting to hurt self
- ☐ Other: _____

Approximately how many hours per day does your child watch TV or play video games? _____
Approximately how many hours per day does your child spend completing homework? _____
Approximately what time does your child go to bed at night? _____ Awake? _____

Describe special areas of interest or hobbies (e.g., art, reading, sports, church activities, scouts, etc.).

Activity	How much time per week?	How long participated?

Please check any of the following events that have happened for anyone in the family in the past 6 months.

- ☐ increase in marital conflict
- ☐ separation or divorce
- ☐ remarriage
- ☐ death in family
- ☐ loss of job
- ☐ change in living situation
- ☐ trauma or injury
- ☐ serious illness/hospitalization
- ☐ new baby
- ☐ jail sentence/legal trouble
- ☐ other _____
- ☐ other _____

Family Background

If any of the child's relatives have had any of the following conditions, please check the condition and write that person's relationship to the child next to it. By relatives, we mean parents, brothers, sisters, grandparents, aunts, uncles, and cousins on both sides.

	Condition	Relationship to child
☐	convulsions, seizures, epilepsy	
☐	speech problems	
☐	slow development	
☐	learning problems in reading, writing, math	
☐	retained/held back in school	
☐	autism/Aspergers	
☐	mental retardation	
☐	hyperactive as a child or (ADD/ADHD) Attention-Deficit/Hyperactivity Disorder	
☐	depression, anxiety, Bipolar (manic-depression)	
☐	other mental illness _____	
☐	suicide attempts	
☐	alcohol or substance abuse/addiction	
☐	thyroid disease (hyperthyroidism/hypothyroidism)	
☐	Other _____	

Thank you. Please return this questionnaire to Dr. Weissglass.