



# Developmental History for Children

Patient Name: \_\_\_\_\_

Patient ID# \_\_\_\_\_

Parent Name: \_\_\_\_\_

Date: \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

## I. Pregnancy

1. Parents age at time of birth Mother \_\_\_\_\_ Father \_\_\_\_\_.
2. Mother's health during pregnancy \_\_\_\_\_.
3. Any substance use before or during pregnancy Yes \_\_\_ No \_\_\_.
4. Tobacco use during pregnancy Yes \_\_\_\_\_ No \_\_\_\_\_.

## II. Delivery

6. Length of pregnancy \_\_\_\_\_ Labor \_\_\_\_\_.
7. Type of delivery Vaginal \_\_\_\_\_ Caesarean \_\_\_\_\_ Breech \_\_\_\_\_.
8. Complications \_\_\_\_\_.
9. Birth weight \_\_\_\_\_ Baby's condition \_\_\_\_\_.

## III. Infancy

10. Child was Bottle Fed \_\_\_\_\_ Breast Fed \_\_\_\_\_ Age weaned \_\_\_\_\_.
11. Child experienced Colic \_\_\_\_\_ Apnea \_\_\_\_\_ Other \_\_\_\_\_.
12. Temperament was Easy \_\_\_\_\_ Difficult \_\_\_\_\_ Other \_\_\_\_\_.

## IV. Developmental Milestones

13. Age when child: Spoke first word \_\_\_\_\_ Crawled \_\_\_\_\_ Walked \_\_\_\_\_ Toilet trained \_\_\_\_\_
14. Current Stressors: \_\_\_\_\_
15. Past Stressors: \_\_\_\_\_
16. Has the child ever experienced trauma or abuse? YES/NO If yes explain: \_\_\_\_\_  
\_\_\_\_\_

## V. Health Status

14. List any/all current health conditions, if any \_\_\_\_\_
15. Current medications w/ dosage, if any \_\_\_\_\_
16. Prior MH treatment YES/NO Helpful? YES/NO Name of most recent provider? \_\_\_\_\_
17. Do you have any reason to believe your child might hurt himself? YES/NO
18. If you answered yes in #17 please explain: \_\_\_\_\_
19. Do you have any reason to believe your child might hurt someone else? YES/NO
20. If you answered yes in #19 please explain: \_\_\_\_\_

## VI. Social Status

17. Household members? \_\_\_\_\_
18. Child has one best friend \_\_\_\_\_ Many friends \_\_\_\_\_ Not Many Friends \_\_\_\_\_ Picked on \_\_\_\_\_
19. Child is a Leader \_\_\_\_\_ Follower \_\_\_\_\_ Loner \_\_\_\_\_.

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**Parent Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**VII. Family History**

20. Please describe any losses or traumatic events that may have affected your child.  
\_\_\_\_\_

21. Please describe any mental health issues of members of the immediate or extended family, either current or in the past. \_\_\_\_\_

22. Please describe any substance abuse issues of members of the immediate or extended Family either current or in the past. \_\_\_\_\_

**VIII. Behavior**

22. The following is a list of behaviors, thoughts or feelings that you may observe in your child. Check all that apply:

**Positive Personality Traits**

confident  
 flexible  
 loyal  
 sensitive  
 respectful  
 optimistic

creative  
 honest  
 happy  
 organized  
 assertive  
 responsible

playful  
 adjusts well  
 compassionate  
 helpful  
 understanding  
 insightful

cooperative  
 loving  
 calm  
 independent

**Negative Personality Traits**

jealous  
 worries  
 angry  
 frightened  
 lazy  
 sensitive  
 low self esteem  
 lonely  
 bored  
 sad  
 tired  
 fighting  
 afraid to leave caretaker  
 strong willed

lying  
 stealing  
 cheating  
 hurting animals  
 setting fires  
 defies authority  
 picky eater  
 wets bed  
 vomits when upset  
 sick often  
 pulls own hair  
 bites nails  
 frequent constipation  
 headaches

stomach ache  
 crying spells  
 problems sleeping  
 easily distracted  
 problems concentrating  
 can't sit still  
 interrupts  
 does not follow instructions  
 refuses to go to school  
 trouble in school  
 legal problems