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DEVELOPMENT AND SOCIOEMOTIONAL HISTORY

Child's name_____ Date_____
Date of Birth_____ Age_____ Ethnicity_____ Sex □ M □ F
School/Teacher_____ Grade_____
Parent/Guardian_____
Address_____

Directions

To the best of your ability, please answer all of the questions, even if some do not seem to apply. If you do not understand any item, please ask me to help you. Information gathered is confidential and maintained in my records. Outside agencies (insurance, police. schools, etc.) do not have access to this information without your written consent.

Person Answering Questions

Name _____
Relationship to this child_____
Address (if different from above)_____
Home/Cell phone_____ Work phone_____
Email Address_____

Referral Information

Why are you seeking help for this child?_____

_____

Why now? (Did a particular incident/event prompt you to come in?) _____

_____

Who referred you to me?_____
What kind of services are you seeking for this child (i.e., therapy, psychological testing, etc.)?_____

_____

Strengths/Areas of Resilience

What are your child's strengths or areas of resilience/grit?_____

_____

_____

_____

Developmental History

Pregnancy

Was this child a planned pregnancy? □ No □ Yes
Was the mother under a doctor's care? □ No □ Yes
Number of previous pregnancies/miscarriages_____
Check any of the following complications that occurred during the pregnancy.

□ Difficulty in conception □ Toxemia □ Abnormal weight gain
□ Measles □ Excessive vomiting □ German measles
□ Excessive swelling □ Emotional problems □ Vaginal bleeding
□ Flu □Anemia □ High blood pressure
□ Other (Rh incompatibility, injury, hospitalization; x-rays, etc)_____
□ Medications used during pregnancy: What kind?_____Which month(s)?_____
□ Alcohol used during pregnancy: Frequency_____
□ Cigarettes used during pregnancy: Frequency_____
□ Other drugs used during pregnancy:

Type of drug/medication	Frequency	Prescription
		□Yes □ No
		□Yes □ No
		□Yes □ No
		□Yes □ No

Birth

At this child's birth, what was the mother's age?_____Father's age?_____
Mother's age at birth of first child?_____
Was this child born in a hospital? □Yes □ No If no, where? _____
Length of pregnancy:_____weeks Birth weight:_____lbs_____oz
Length of labor:_____hours Apgar score:_____
Child's condition at birth_____
Mother's condition at child's birth_____
Check any of the following complications that occurred during birth.
□ Forceps used □ Breech birth □ Labor induced □Caesarean delivery
□ Other delivery complications: Describe_____
_____
□ Incubator: How long?_____
□Jaundiced: Bilirubin lights? □No □ Yes .....If yes, how long?_____
□Breathing problems right after birth: Describe_____
Supplemental oxygen? □ No □ Yes .If yes, how long?_____
Was anesthesia used during delivery? □No □ Yes If yes, what kind?_____
Length of stay in hospital: Mother:_____days Child:_____

Development

At what age did this child first do the following? *Please indicate year/month of age.*

_____Turn over
_____Sit alone
_____Crawl
_____Stand alone
_____Walk alone
_____Walk up stairs
_____Walk down stairs
_____Show interest in or attraction to .sound
_____Understand first words
_____Speak first words
_____Speak in sentences

At what age was the child toilet trained? Days:_____ Nights:_____
Did bed-wetting recur after toilet training? □No □ Yes If yes, at what age?_____
Did bed-soiling recur after toilet training? □No □ Yes If yes, at what age?_____
Were there any medical reasons far bed-wetting or -soiling? □No □ Yes If yes, please describe_____
Has this child experienced any of the following problems? □No □ Yes If yes, please describe_____

Walking difficulty	□ Yes _____
Unclear speech	□ Yes _____
Feeding problem	□ Yes _____
Underweight problem	□ Yes _____
Overweight problem	□ Yes _____
Colic	□ Yes _____
Sleep problem	□ Yes _____
Eating disorder	□ Yes _____
Difficulty learning to ride a bike	□ Yes _____

During this child's first 4 years, were any special problems noted in the following areas? If yes, please check and describe.

Eating	□ Yes _____
Motor skills	□ Yes _____
Sleeping too much	□ Yes _____
Temper tantrums	□ Yes _____
Failure to thrive	□ Yes _____
Separating from parents	□ Yes _____
Excessive crying	□ Yes _____

Which hand does this child use for writing or drawing?_____
Eating?_____Other (throwing,etc.)?_____
Has this child been forced to change writing hand? □No □ Yes

Personality/Temperament

How would you describe your child's personality? (e.g., intense, interested in her/his surroundings, friendly with strangers, affectionate, attached, overactive, independent, more interested in people, more interested in objects, a self-starter, sensitive, shy, etc.):

As an infant?_____

As a toddler?_____

As a 3-5 year old?_____

As a 6 year old?_____

7-8 year old?_____

8-10 years old?_____

10-12 years old?_____

12-14 years old?_____

14-18 years old?_____

Medical History

Childhood Illnesses/Injuries

Please check the illnesses this child has had and indicate approximate age (year/month).

- ☐ Measles _____
- ☐ German measles _____
- ☐ Diphtheria _____
- ☐ Mumps _____
- ☐ Chicken pox _____
- ☐ Tuberculosis _____
- ☐ Whooping cough _____
- ☐ Rheumatic fever _____
- ☐ Diptheria _____
- ☐ Meningitis _____
- ☐ Encephalitis _____
- ☐ Anemia _____
- ☐ Fever above 104° _____
- ☐ Scarlet fever _____
- ☐ Head injury: Describe _____
- ☐ Coma or loss of consciousness: Describe _____
- ☐ Sustained high fever: Describe _____

Please describe other serious illnesses or operations:

Illness/Operation	Age

Has this child ever been on long-term medication (more than 6 months)? □No □ Yes
If yes, when? _____ What kind? _____

Neurological (check if apply)

Seizures/convulsions	□ Yes if yes, describe _____
Speech defects	□ Yes _____
Accident prone	□ Yes _____
Bites nails	□ Yes _____
Sucks thumb	□ Yes _____
Grinds teeth	□ Yes _____
Has tics/twitches	□ Yes _____
Bangs head	□ Yes _____
Rocks back and forth	□ Yes _____

Allergies (check if apply)

Allergy to medicine	□ Yes if yes, describe _____
Allergy to food	□ Yes _____
Other allergies	□ Yes _____

Hearing (check if apply)

Ear infections	□ Yes _____
Hearing problems	□ Yes _____
Ear tubes	□ Yes _____

Date of most recent hearing exam_____ Results? (Normal/Abnormal)_____

Vision

Vision problems □ Yes _____
Wears glasses or contacts □ Yes _____

Date of most recent vision exam_____ Results? (Normal/Abnormal)_____

Medical Care

Child's physician_____ Telephone_____
How often does this child see a doctor?_____ Date of last visit_____
Is this child currently on medication? □No □ Yes
If yes, indicate type and reason_____

Educational History

Preschool

Does or did your child attend preschool? □No □ Yes At what age?_____
Any problems in preschool? □No □ Yes Describe:
Does or did your child attend kindergarten? □No □ Yes At what age?_____
Any problems in kindergarten? □No □ Yes Describe:

Elementary/High School

List schools attended by your child

Year(s)	Age(s)	Grade(s)	School	Location	Reason for Leaving

Has your child had any of the following experiences? (check all that apply)

Has been retained a grade in school? □Yes _____
Has skipped a grade in school? □Yes _____
Has difficulty with reading? □Yes _____
Has difficulty with math? □Yes _____
Has difficulty with writing assignments? □Yes _____
Gets poor grades? □Yes _____
Has been placed in a gifted program? □Yes, when _____
Has been tested for special education? □Yes, when _____
Currently is placed in special education class? □Yes
If yes, what type of class?_____ Hours per day_____
Under what classification? LD_____ SED_____ OHI_____ Speech/Lang_____
Is absent from school frequently? □Yes_____

Social Relations

Does your child play/socialize well with others?	□No	□ Yes
Prefer playing/socializing with younger children?	□No	□ Yes
Prefer playing/socializing with older children?	□No	□ Yes
Has difficulty making friends?	□No	□ Yes
Fights frequently with peers?	□No	□ Yes
Prefers to play/be alone?	□No	□ Yes
Are there children in the neighborhood with whom this child could play/socialize?	□No	□ Yes
What role does your child take in peer group games (i.e., leader, follower, aggressor)?		
Does your child show affection easily?	□No	□ Yes
Does your child strike out at parents or siblings?	□No	□ Yes

Family History

Discipline

Who administers discipline?_____

What approach is used? _____

What do you do when your child acts aggressive? _____

What do you do when your child does not follow directions? _____

If applicable, do you and your partner agree on ways to discipline your child(ren)? □No □ Yes

If No, explain _____

What things do you most enjoy about being with your child?_____

Least enjoy:_____

Family History

Please indicate sequence of events regarding your relationship with your child's other biological parent, where applicable.

Length of time dated_____Married/cohabitation (dates)_____

Separation/divorce (dates)_____

Other subsequent relationships/marriages? To whom and when?_____

List other children:

Name	Date of Birth	Age

Any deaths in the family, (including pets)?_____When?_____

Indicate family moves (when and where)_____

Other stressors and dates occurred (e.g. divorce, marriage, illness, school changes, significant changes, etc.):_____

Name additional significant others for child, (for example, step-parent, family friend, grandparent, mentor)? _____

Family Health

Have any family members had any of the following? If yes, please circle which ones apply and specify family member's relationship to this child

Cancer _____
Cystic fibrosis _____
Diabetes _____
Migraine headaches _____
Multiple sclerosis _____
Physical handicap _____
Alzheimer's disease _____
Muscular dystrophy
Sickle-cell anemia/Thalassemia
Tay-Sachs disease
Tourette's syndrome
Birth defect
Cerebral palsy
Alcohol/drug abuse
History of physical abuse
History of molestation
Behavioral disorder
Mental retardation

Mental Illness _____
Schizophrenia _____
Depression _____
Severe mood swings _____
Rages _____
Spending sprees _____
Suicides _____
Tics
Phobias
Nervous breakdown
Reading problem
Other learning problem
Speech/language problem
Food allergies
Severe head injury
Creative/artistic talents
Incarceration (jail/prison)
Seizures or epilepsy

Psychological History

Have you/Has your child ever had psychological counseling or therapy? No Yes
Type of counseling _____
For what? _____
When? _____ How long/# of sessions: _____

Have you/Has your child ever had a neurological/neuropsychological exam? No Yes
If yes, neurologist/neuropsychologist's name _____
City _____ Date of exam _____
Reason for exam _____

Have you/Has your child ever had a psychological or psychiatric exam? No Yes
If yes, doctor's name _____
City _____ Date of exam _____
Reason for exam _____

Do you/Does your child use alcohol/drugs? No Yes
What is used _____ How long _____
Has your child ever been involved with a Child Protective Services Investigation? No Yes
If yes, please specify _____