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Child Developmental History Record

A. Preliminary Information

Child's name: _____ Birthdate: _____ Age: _____

Person(s) completing this form: _____ Today's date: _____

Relationship to this child: _____

Address: _____

School: _____ Grade: _____

Reason for seeking help at this time: _____

Who referred you to my practice: _____

What kind of services are you seeking? (for example, therapy, psychological testing, parenting Consultation) _____

B. Family Composition

Mother's name: _____ Birthdate: _____ Home phone: _____

Address: _____

Currently employed: No Yes, as: _____ Work phone: _____

Father's name: _____ Birthdate: _____ Home phone: _____

Address: _____

Currently employed: No Yes, as: _____ Work phone: _____

Parents are currently Married Divorced Remarried Never married Other: _____

Child's custodian/guardian is: _____

Stepparent's name: _____ Birthdate: _____ Home phone: _____

Address: _____

Currently employed: No Yes, as: _____ Work phone: _____

Any other guardian? _____ Birthdate: _____ Home phone: _____

Address: _____

Currently employed: No Yes, as: _____ Work phone: _____

Please list all brothers and sisters, and any other children/adults living with the family:

Has the child experienced any deaths in the family or other similar losses: _____

C. Developmental History

Pregnancy and delivery

Was your child adopted? _____

Prenatal medical illnesses and health care: _____

Was the child premature? _____ Weight and height at birth: _____

Mother's age at the time of the birth of this child _____

Please list any complications that occurred during the pregnancy

- ___ High blood pressure
- ___ Toxemia
- ___ Emotional problems
- ___ Anemia
- ___ Alcohol use during pregnancy
- ___ Cigarettes use during pregnancy
- ___ Medications used during pregnancy _____
- ___ Hospitalizations during pregnancy _____
- ___ Maternal injuries
- ___ Other _____

Any problems or complications at birth? _____

Child's and mother's condition at birth _____

The first few months of life

Breast-fed? _____ If so, for how long? _____

Any allergies? _____

Sleep patterns or problems: _____

Personality: _____

Developmental Milestones: At what age did this child do each of these?

Sat without support: _____

Crawled: _____

Walked without holding on: _____

Ate with a fork: _____

Stayed dry all day: _____

Stayed dry all night: _____

Did bed-wetting occur after toilet-training? Yes No If yes, until what age? _____

Did bed-spoiling occur after toilet training? Yes No If yes, until what age? _____

Were there any medical reasons for bed-wetting? Yes No If yes, please describe _____

Dressed self completely: _____

Age when child said first word understandable to strangers: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

During the child's first four years, were there any difficulties in the following areas?

Eating	Yes	No
Motor Skills	Yes	No
Sleeping too much	Yes	No
Sleeping too little	Yes	No
Temper tantrums	Yes	No

Failure to thrive	Yes	No
Separating from parents	Yes	No
Excessive Crying	Yes	No
Colic	Yes	No

Temperamental factors: Please describe your child's temperament

High Activity level, unusually active	Yes	No
Impulsive	Yes	No
Fearful	Yes	No
Accident prone	Yes	No
Short attention span	Yes	No
Irritable	Yes	No
Poor adaptation to change	Yes	No
Colic	Yes	No
Frequent temper tantrums	Yes	No
Eating Problems	Yes	No
Sleep Problems	Yes	No
Clumsiness	Yes	No
Rigid, tense instead of cuddly	Yes	No

Is there anything else that may describe your child as a toddler:

Environmental Risk Factors: Did your child experience any of the following:

Significant loss or separation from a loved one	Yes	No
Sexual Abuse	Yes	No
Physical Abuse	Yes	No
Emotional Abuse	Yes	No
Violence in the family	Yes	No
Neglect	Yes	No
Extreme family stress	Yes	No
Economic problems/financial stress	Yes	No
Poor diet	Yes	No
Exposure to heavy metals (lead)	Yes	No

Were there any other traumas during the child's childhood? If yes, please describe:

D. Health

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
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Did your child experience any of the following:

Allergies	Yes	No
Asthma	Yes	No
Encephalitis	Yes	No
Meningitis	Yes	No
Fainting Spells/blackouts	Yes	No

Careless accidents	Yes	No
Frequent emergency room visits	Yes	No
Broken bones	Yes	No
Hospitalized for any reason	Yes	No
Loss of consciousness	Yes	No
Seizures	Yes	No

Has the child ever been on long-term medication (more than 6 months)? Yes No
 If yes, please explain _____

Has this child ever had a neurological exam? Yes No
 If yes, please explain _____

Has this child ever had a psychiatric or psychological exam? Yes No
 If yes, please explain _____

Has this child ever seen a psychologist, counselor or therapist for counseling? Yes No
 If yes, please explain _____

E. Residences

Homes

Dates		Location	Reason for moving	With whom	Any problems?
From	To				
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Residential placements, institutional placements, or foster care (if applicable)

Dates		Program name or location	Reason for placement	Problems?
From	To			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

F. Educational Experiences

School (Name, district, address, phone)	Grade	Age	Teacher
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate if any of the following are applicable:

Failed any grades	Yes	No
Retained in grade	Yes	No
Skipped a grade	Yes	No
Took special classes	Yes	No
Evaluated by school	Yes	No
Labeled by school	Yes	No
Had learning difficulties	Yes	No
Received tutorial assistance	Yes	No
Suspended from school	Yes	No
Reading problems	Yes	No
Arithmetic problems	Yes	No
Writing problems	Yes	No
Performance was variable or unpredictable	Yes	No
Told that child was not achieving up to potential	Yes	No
Does the child dislike school	Yes	No

Did any other significant events occur during school?

If yes, please describe: _____

Describe the child's academic progress thus far: _____

G. Recreational Information

List hobbies, sports; recreational, TV, and toy preferences; etc.: _____

Does the child have problems relating to or playing with other children? _____

Does the child fight frequently with playmates? _____

Does the child prefer playing with younger children? _____

Does the child have difficulty making friends? _____

Does the child prefer to play alone? _____

H. Extended Family History

Has any individual in the child's immediate or extended family ever been diagnosed with the following:

Learning Disabilities? If yes, please list who: _____

Anxiety? If yes, please list who: _____

Depression? If yes, please list who: _____

Manic-Depression? If yes, please list who: _____

Substance use or abuse? If yes, please list who: _____

Any other diagnosis? If yes, please list who: _____

I. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

