Oceanside Family Therapy & Assessments

Child Developmental History Form

Date Form Completed: _____ **Person Completing the Form:** _____
Name and relationship to client

Client's Name: _____ **Sex:** M / F **Date of Birth:** _____

Address: _____
Street City State Zip

Phone Number: _____ **Email Address:** _____

REASONS FOR EVALUATION

Please list the reason(s) the client is being referred for the evaluation:

1. _____

_____

2. _____

_____

3. _____

_____

When did these problems begin?

What are you goals for this evaluation?

Has the client ever received the diagnosis of an autism spectrum disorder? ☐ **Yes** ☐ **No**

If yes, in what month & year _____ and by whom

_____

FAMILY INFORMATION

Mother/Guardian Name: _____

Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Father/Guardian Name: _____ Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Parents are:
- ☐ Married
- ☐ Unmarried, Living Together
- ☐ Never Married, Living Together
- ☐ Separated
- ☐ Divorced
- ☐ Mother Deceased
- ☐ Father Deceased

Child lives with:
- ☐ Biological Mother
- ☐ Biological Father
- ☐ Step-parent
- ☐ Adoptive Parent (specify) _____
- ☐ Grandparent
- ☐ Legal Guardian (specify) _____
- ☐ Other (specify) _____

Sibling Information

Name of sibling	Sex	Age	Different Father?	Different Mother?	List any health/behavior/ learning problems	Lives with child?
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N

How well does your child get along with his/her siblings?
☐ Very Well ☐ Good ☐ Average ☐ Fair ☐ Poor

Is English the client's primary speaking language: ☐ Yes ☐ No

If no, what is the client's primary language: _____

What is the client's secondary language:
_____

Child Care and Discipline

Who is primarily responsible for the client's care? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Who is mainly in charge of discipline in the home? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Please describe discipline techniques: _____

_____

FAMILY PSYCHIATRIC HISTORY

Condition/Disorder	Mother	Father	Brother	Sister	Grandparent	Aunt/ Uncle	Other Close Relatives
Alcoholism							
Anxiety							
ADHD/ADD							
Autism Spectrum Disorder							
Bipolar Disorder							
Depression							
Epilepsy/Seizure Disorder							
Genetic Condition							
Hospitalized for Emotional Problems							
Intellectual disability							
Jail Time/Incarceration							
Language disorder							
Learning Disability							
Motor or Vocal Tics							
Psychosis or Schizophrenia							
Special Education							
Substance Abuse							

Suicidal Ideation/Attempt							

PREGNANCY AND BIRTH HISTORY

Parental ages when client was born: Mom _____ Dad _____

Was this pregnancy full term? ☐ **Yes** ☐ **No** If not, how many weeks before or after the expected due date was the baby born? _____ weeks ☐ **BEFORE** ☐ **AFTER** due date

Pregnancy number: 1st, 2nd, 3rd, 4th, other ____ Totals: # of pregnancies _____ # of miscarriages _____

Was this a multiple birth? ☐ **Yes** ☐ **No** ☐ **UK** ; if yes:☐ **Twins** ☐**Triplets** ☐**Quadruplets**

Were the babies identical? ☐ **Yes** ☐ **No** ☐ **UK** (unknown)

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.): _____

Mother's health during pregnancy:

☐ No health problems during pregnancy
☐ Poor weight gain
☐ Seizures
☐ Health during pregnancy not known
☐ Severe nausea {☐ with dehydration}
☐ Infections (Flu, measles, CMV)

☐ High blood pressure
☐ Eclampsia/Toxemia

☐ Other (specify)_____
☐ Rh (blood group) incompatibility

List medications taken during this pregnancy: _____

_____

_____

Did the mother consume more than 2 glasses of alcohol a day during this pregnancy? ☐ Yes ☐ No

Did the mother smoke during pregnancy? ☐ Yes ☐ No

Did the mother consume illegal substances during the pregnancy? ☐ Yes ☐ No

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Labor and Delivery:

☐ No problems during labor and delivery ☐ Not known

Please note whether any problems occurred during labor or delivery (✓ all that apply):

☐ Excessive bleeding
☐ Meconium staining
☐ Forceps Used
☐ Umbilical cord around baby's neck

☐ Fever or infection of mother
☐ Placenta previa or abruption
☐ Breathing difficulties of child
☐ Placenta (bag of water) broke more than 1 day before delivery
☐ Other (specify): _____

Baby was born ☐ head first ☐ breech (feet first) ☐ vaginal ☐ Cesarean (Why? _____

Birth weight _____ lbs _____ oz Length _____ in. (if known) Head circumference _____ in. (if known) Apgar Scores (if known): _____ at 1 min _____ at 5 min

Newborn period:

Was the child healthy as a newborn? ☐ **Yes** ☐ **No** If not, please describe the problems and treatment:

_____

_____

Was the child born with any birth defects? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Did the child require treatment in a newborn intensive care unit? ☐ Yes (for _____ days) ☐ No

Did the baby require any special care immediately after birth? ☐ Yes ☐ No

If yes, √ all that apply

☐ Breathing problems (requiring ☐ oxygen ☐ ventilator *(with a tube in windpipe)*
☐ Placement in an incubator
☐ Blood transfusions
☐ Significant muscle weakness or paralysis
☐ Poor muscle tone
☐ Seizures
☐ Feeding difficulties
☐ Excessive sensitivity to noise/stimulation
☐ Jaundice treated with lights
☐ Infection
☐ Surgery (describe): _____

DEVELOPMENTAL HISTORY

Social Development

Did you notice any delays in the client's social development? ☐ Yes ☐ No

As an infant, did the client:

Enjoying cuddling? ☐ Yes ☐ No

_____

Tend to be fussy/irritable? ☐ Yes ☐ No _____

Make appropriate eye contact? ☐ Yes ☐ No _____

Respond to his/her name? ☐ Yes ☐ No _____

In the first four years of life, were any special problems noted in the following areas?

If yes, please describe below:

Temper Tantrums ☐ Yes ☐ No _____

Separating from parents ☐ Yes ☐ No _____

Excessive crying ☐ Yes ☐ No _____

Playing with other children ☐ Yes ☐ No _____

Speech and Language Development

Did you notice any delays in the client's language development? ☐ Yes ☐ No

If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

Show interest in sound *(by 3 months)* ☐ Yes ☐ No _____

Babbling *(by 4 to 6 months)* ☐ Yes ☐ No _____

Understanding words *(by 6-11 months)* ☐ Yes ☐ No _____

Speaking first words *(by 12 months)* ☐ Yes ☐ No

_____

Speaking in short phrases *(by 24 months)* ☐ Yes ☐ No

_____

Motor Development

Did you notice any delays in the client's motor development? ☐ Yes ☐ No

If yes, please specify: _____

Did the following milestones develop on time? *Please specify age (year/month).*

Turn over (by 6 months) ☐ Yes ☐ No _____

Sit alone (by 9-12 months) ☐ Yes ☐ No _____

Crawl (by 9-12months) ☐ Yes ☐ No _____

Stand alone (by 9-12 months) ☐ Yes ☐ No _____

Walk alone (by 12-18 months) ☐ Yes ☐ No _____

Walk upstairs (by 36 months) ☐ Yes ☐ No _____

Walk downstairs (by 48 months) ☐ Yes ☐ No _____

Running ☐ Yes ☐ No _____

Which hand does the client use for writing or drawing? ☐ Right ☐ Left ☐ Both

Eating? ☐ Right ☐ Left ☐ Both

Throwing? ☐ Right ☐ Left ☐ Both

Daily Living

When was the client toilet trained? Days: _____ Nights:_____

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

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

Does your child have difficulty with sensory processing?

If yes, please describe below:

Tolerating Food Textures ☐ Yes ☐ No _____

Gagging or Vomiting ☐ Yes ☐ No _____

Tolerating Clothing ☐ Yes ☐ No _____

Tolerating Touch from Others ☐ Yes ☐ No

_____

Does Not Notice Pain ☐ Yes ☐ No

_____

Other

_____

Significant <u>LOSS</u> of an acquired skill or skills (not just a delay)? For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning ☐ Age of loss: _____ months; Explain: _____

_____

Speech / language ☐ Age of loss: _____ months; Explain: _____

_____

Problem solving ☐ Age of loss: _____ months; Explain: _____

_____

_____

Motor coordination ☐ Age of loss: _____ months; Explain: _____

_____

Bladder/bowel control ☐ Age of loss: _____ months; Explain: _____

_____

<u>MEDICAL HISTORY</u>

☐ No serious illnesses or injuries in the **past** ☐ No serious illnesses or injuries **now**

Date(s) of Hearing Test(s): _____

Results of Hearing Test(s):_____

Date(s) of Vision Test(s): _____

Results of Vision Test(s):_____

Date	Age	Diagnosis/Illness	Past	Now	Date	Age	Diagnosis/Illness	Past	Now
		Serious Injuries	☐	☐			**Lung/breathing Problems**	☐	☐
		Serious head injury	☐	☐			Asthma	☐	☐
		Other serious injury	☐	☐			Pneumonia	☐	☐
		Loss of consciousness	☐	☐			Apnea or irregular breathing	☐	☐
		Sleep Problems	☐	☐			Other: _____	☐	☐
		Neurological Problems	☐	☐			**Stomach/bowel Problems**	☐	☐
		Birth abnormality	☐	☐			Swallowing problems	☐	☐
		Seizures (any type)	☐	☐			Gastroesphageal reflux	☐	☐
		Other: _____					Chronic abdominal pain	☐	☐
		Vision Problem	☐	☐			Chronic diarrhea	☐	☐
		Vision problems at birth	☐	☐			Chronic constipation	☐	☐
		Requires glasses/contacts	☐	☐			Other: _____	☐	☐
		Other: _____	☐	☐			**Kidney/Bladder Problems**	☐	☐
		Hearing Problem	☐	☐			Abnormalities at birth	☐	☐
		Hearing problems at birth	☐	☐			Kidney/bladder infections	☐	☐
		Deafness	☐	☐			Other: _____	☐	☐
		Chronic ear infections	☐	☐			**Muscle/bone/joint) Problems**		
		Ear tubes	☐	☐			Abnormalities at birth	☐	☐
		Other: _____	☐	☐			Scoliosis or spinal curvature	☐	☐
Date	Age	**Diagnosis/Illness**	**Past**	**Now**	**Date**	Age	**Diagnosis/Illness**	**Past**	**Now**
		Dental Problem	☐	☐			**Circulatory Problem**	☐	☐
		Abnormally shaped/ missing teeth	☐	☐			Anemia	☐	☐

		Extractions/cavities	☐	☐			Sickle cell disease	☐	☐
		Dental braces	☐	☐			Chronic low platelet count	☐	☐
		Other: _____	☐	☐			Bleeding /bruising problem	☐	☐
		Skin Problem	☐	☐			Other: _____	☐	☐
		Eczema	☐	☐			**Hormone Problem**	☐	☐
		Ash leaf patches	☐	☐			Sugar diabetes	☐	☐
		Café-au-lait spots	☐	☐			Early puberty	☐	☐
		Other: _____	☐	☐			Late or incomplete puberty	☐	☐
		Growth Problem	☐	☐			Other: _____	☐	☐
		Failure to gain weight	☐	☐			**Mental Health problem**	☐	☐
		Obesity	☐	☐			ADHD	☐	☐
		Short stature	☐	☐			Oppositional defiant disorder	☐	☐
		Tall stature	☐	☐			Anxiety disorder	☐	☐
		Other: _____	☐	☐			Obsessive-compulsive disorder	☐	☐
		Heart Problem	☐	☐			Depression	☐	☐
		Heart abnormalities at birth	☐	☐			Bipolar disorder (manic-depressive)	☐	☐
		Heart surgery	☐	☐			Schizophrenia	☐	☐
		Heart rhythm abnormalities	☐	☐			Tic disorder (e.g., Tourette)	☐	☐
		High blood pressure	☐	☐			Intellectual disability	☐	☐
		Other: _____	☐	☐			Eating disorder (e.g., anorexia)	☐	☐
							Other: _____	☐	☐

I have confirmed with my child's Primary Care MD that his/her immunizations are up to date. ☐ **Yes** ☐ **No**
If no, explain:_____

Specialized neurological or genetic tests:

☐ No neurological or genetic testing has been done

If done	Date (if known) Month/Year	Test	Normal Result	Abnormal Result	Unknown Result
☐		EEG (brain wave test)	☐	☐	☐
☐		CT scan	☐	☐	☐
☐		MRI scan	☐	☐	☐
☐		PET/SPECT/ scan roscopy	☐	☐	☐
☐		Other scan (specify):	☐	☐	☐
☐		Chromosomal microarray	☐	☐	☐
☐		Chromosomal analysis (karyotype)	☐	☐	☐
☐		DNA testing for fragile X syndrome	☐	☐	☐
☐		Other genetic test:	☐	☐	☐

List all hospitalizations and surgeries for the client, include overnight stays (medical or behavioral)

☐ No past hospitalizations or surgery

Reason for hospitalization/surgery	Age	Length of stay

Allergies (to medications, foods, environmental antigens, etc.)

☐ No past or current allergies

Source (medication, food, etc.)	Nature of reaction (hives, trouble breathing, etc.)

Current Medications

☐ No medications taken **now**

☐ Medications are being taken now, but the names are not known

Medication	Dosage	Age at start	Reason for medication	Improved	
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N

Name of person prescribing the medications: _____

RESOURCES: Please indicate resources/services being received **now**

☐ No resources/services are being received now

☐ Early Intervention Services (Agency:_____)

☐ Speech/Language therapy ☐ Psychiatry services ☐ Behavioral therapy ☐ Group therapy ☐ Physical therapy

☐ Occupational therapy ☐ Case management ☐ Wraparound services (WRAP) ☐ Mobile Therapist (MT)

☐ Behavior Specialist Consultant (BSC) ☐ Therapeutic Staff Support (TSS) ☐ Other: _____

EDUCATIONAL HISTORY

School name: _____ Phone:

Grade in school: __ (ever repeat a grade? Yes / No) Teacher (or best contact): _____

Is the client currently on a formal education plan in school? ☐ **Yes** ☐ **No**

If yes, please check: □ IEP □ 504 Plan

What best describes the client's current educational program?

Full time in a regular class ☐

Time split between regular and special education classes ☐

Special education class ☐

Aide/Paraprofessional or extra help ☐

Specialized school ☐

Home schooled ☐

Please indicate the educational program in which the client participated during his/her school* years:

School Year	Type of School		Type of Class		*Any Special Services*		
	Regular* Special		Regular* Special*		Yes	No	Type
3-5 preschool							

Kindergarten							
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							
11th							
12th							

*** REGULAR school applies to public or private schools for children without disabilities.**
SPECIAL school applies to any schools intended for children with disabilities

SOCIAL AND BEHAVIORAL FUNCTIONING

Peer Relationships
Please indicate how the client relates to peers:

- ☐ Has problems relating to other children
- ☐ Has difficulty making friends
- ☐ Fights frequently with peers
- ☐ Prefers playing with younger children
- ☐ Prefers playing with older children
- ☐ Prefers to play alone
- ☐ Has a best friend

What role does the client take in peer groups? ☐ Leader ☐ Follower ☐ Some of Each

How many friends does the client have? _____

Recreational Interests
What does the client enjoy?

- ☐ Sports _____
- ☐ Hobbies_____
- ☐ Other _____

What are the client's personal strengths?

What do you enjoy most

What are your hopes for the client's future?

Any concerns that you would like to add that were not covered on this form?

Please return to Nicole Story EDS MED LMHC LMFT, 328 2nd Ave N, Jacksonville Beach, Florida 32250

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