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Developmental History Form

Date _____

(Please feel free to continue entries on back of pages, if needed.)

A. Child's full name _____

Child's Address _____

Date of Birth _____ Age _____ Sex: M F

A. Form filled out by _____

Phone _____ Relationship to Child _____

B. Briefly describe why you are seeking an evaluation for your child:

How long have the reasons for this evaluation existed?

Have you previously sought help? No ____ Yes ____ If yes, please describe why, where and when:

What would you like to learn from this evaluation?

C. Persons with legal custody of child (state if adoptive, step, or foster parent):

1. Name _____ Relationship to child _____

Address (if different from child's) _____

Home Phone _____ Birth Date _____ Highest Education Completed _____

Cell Phone _____ E-mail Address _____

Usual Type of Work _____ Place of Work _____

Work days/hours _____ Work Phone _____

Presently married? Yes _____ No _____ Any previous marriages? Yes _____ No _____

2. Name _____ Relationship to child _____

Address (if different from child's) _____

Home Phone _____ Birth Date _____ Highest Education Completed _____

Cell Phone _____ E-mail Address _____

Usual Type of Work _____ Place of Work _____

Work days/hours _____ Work Phone _____

Presently married? Yes _____ No _____ Any previous marriages? Yes _____ No _____

If divorced, who has legal custody of the child? _____

D. Adults and children living in child's home, if not listed above:

Name	Age	Sex	Relationship to child (state if step, adoptive, foster, unrelated)

How does child get along with his/her sibling(s)? _____

E. Child's brothers and sisters not living in child's home:

Name (state if half, step, or adoptive) Age Sex Living Where? How often does s/he see child?

F. Child care arrangements: Does anyone beside parents take care of the child on a regular basis? No Yes If yes, please answer all that apply:

Babysitter in child's home: Hrs./wk: _____ Babysitter outside child's home: Hrs/wk _____

G. Child's Medical History

	No	Yes	Please Describe
1. Medical problems during mother's pregnancy with this child	_____	_____	_____
2. Medications during pregnancy?	_____	_____	_____
3. Did mother smoke or use alcohol or drugs during pregnancy?	_____	_____	_____
4. Any stress during pregnancy? (such as marital, job, money, living conditions, alcohol/drug problems?)	_____	_____	_____
5. Problems during labor or delivery (such as prolonged labor, bleeding, breech birth)	_____	_____	_____
6. Was the child born prematurely?	_____	_____	_____
7. Birthweight: _____ lbs. _____ oz.			
8. Problems in newborn period or infancy? (such as being born blue, birth defects, jaundice, seizures, infections, injuries, feeding or sleep problems)	_____	_____	_____
9. Was child challenging to care for as a baby?	_____	_____	_____
10. Does the child have allergies? (e.g., dust, pollen, pets)	_____	_____	_____
11. Does the child have eating problems? (too much/too little)	_____	_____	_____
12. Please describe below all severe illnesses, accidents, operations, handicaps and repeated medical problems (such as ear infections, headaches, broken limbs, tonsillectomy), specifying age, treatment, etc.			_____

13. Are you concerned about any aspect of the child's health? _____

14a. Does child take any medication now for any purpose? _____ If yes, please describe below

Name of Medication	Dose	Purpose	Effect (include side effects)	Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

b. Was any medication ever prescribed for behavior problems? No _____ Yes _____ Please describe:

Name of Medication	Dose	Purpose	Effect (include side effects)	Doctor
_____	_____	_____	_____	_____

Child's pediatrician/physician _____ Phone# _____

Pediatrician's address _____

Date of last complete checkup _____ Outcome _____

H. Child's Developmental History

	No	Yes	Please describe
1. Have you noticed any problems in development?	_____	_____	_____
2. Were any of the following difficult or slow to develop?			
a. walking alone	_____	_____	_____
b. first words	_____	_____	_____
c. combining words into phrases	_____	_____	_____
d. bowel training	_____	_____	_____
e. bladder training	_____	_____	_____
f. staying dry at night	_____	_____	_____
g. riding bike without training wheels	_____	_____	_____
h. tying shoes	_____	_____	_____
i. gross motor coordination	_____	_____	_____
j. fine motor coordination	_____	_____	_____
3. Have there been problems in the following areas?			
a. discipline	_____	_____	_____
b. temper or fighting	_____	_____	_____
c. moods	_____	_____	_____
d. relationships with others	_____	_____	_____
e. eating	_____	_____	_____
f. bedtime, sleeping	_____	_____	_____
g. other behaviors (please specify)	_____	_____	_____

I. Child's Temperament

	No	Yes	Please Describe
1. Is your child overactive?	_____	_____	_____
2. Does your child have trouble paying attention?	_____	_____	_____
3. Does your child have trouble staying with one activity, jumping from one thing to another, or failing to finish?	_____	_____	_____
4. Does your child fluctuate from happy to sad quickly with little apparent cause?	_____	_____	_____
5. Does your child get frustrated easily?	_____	_____	_____
6. Is your child unusually irritable?	_____	_____	_____
7. Does your child get upset by abrupt changes?	_____	_____	_____
8. Are your child's emotional responses unpredictable?	_____	_____	_____
9. Does it take your child a long time to warm up to new situations or people?	_____	_____	_____

- 10. Does your child react strongly to physical pain? _____
- 11. Does your child react strongly to other things? _____
- 12. Other concerns about your child's temperament? _____

J. Family History: Has any relative of the child had the following? If so, specify relationship to child.

	No	Yes	Relationship to child	Please Describe
1. <i>Neurological</i> disease, such as seizures, fits, weaknesses, etc.	_____	_____	_____	_____
2. <i>Medical</i> disease, such as diabetes, thyroid disease, heart disease, etc.	_____	_____	_____	_____
3. <i>Mental</i> illness (schizophrenia, manic depressive episodes, etc.)	_____	_____	_____	_____
4. <i>Physical or sensory</i> disabilities (motor, vision, sight, etc.)	_____	_____	_____	_____
5. Mental retardation	_____	_____	_____	_____
6. Learning problems	_____	_____	_____	_____
7. Behavior problems	_____	_____	_____	_____
8. Excessive use of alcohol	_____	_____	_____	_____
9. Excessive use of drugs	_____	_____	_____	_____
10. Trouble with the law	_____	_____	_____	_____
11. Trouble holding a job	_____	_____	_____	_____
12. Suicidal behavior	_____	_____	_____	_____
13. Other (please specify)	_____	_____	_____	_____

K. Current Living Situation

	Yes	No	Please Describe
1. Has anyone in your family seen a psychologist, psychiatrist or other mental health worker? If yes, why?	_____	_____	_____
2. Have there been recent major changes or stresses in your living situation or family?	_____	_____	_____

L. Child's School History

1. Did your child ever receive Early Intervention services (infant/toddler or preschool)? Yes _____ No _____
- If yes, what kind and where? _____
- _____
- How often (frequency and time/session)? _____ For how long (duration)? _____
- 2.. Did child attend preschool? Yes _____ No _____ Where? _____ How long? _____
- Any problems during that time? Yes _____ No _____ Please describe: _____
- _____
- _____

3. Has your child had learning problems? No ___ Yes ___ If yes, please describe below.

4. Please list all schools your child has attended thus far since preschool.

Elementary School(s) _____

Intermediate/Middle School(s) _____

High School(s) _____

College(s) _____

3. Has your child ever repeated a grade? No ___ Yes ___ Grade ___ If yes, why, and what was the outcome?

3. Has your child had social or behavioral problems in school? No ___ Yes ___ If yes, please describe.

4. Has the child ever had a psychoeducational evaluation? No ___ Yes ___ When? _____

By whom? _____

What were the findings?

5. Is your child receiving special help at school right now? No ___ Yes ___ If yes, please describe below.

6. Any other school concerns? No ____ Yes ____ If yes, please describe below

M. Other Information

1. In what groups and leisure activities does your child participate?

2. Please describe your child's strengths.

3. What do you see as your child's weaknesses?

4. Please feel free to write down anything else you think I should know.

Thank you very much!