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BRIEF DEVELOPMENTAL HISTORY FOR MINORS

Filled out by: _____ Date_____
(Name and relationship to pt.)

1. Child's Name:_____ Birthdate:_____

Sex: _____ Age: _____

2. Home/Cell #: _____ Parents Work #:_____

May we call you at home? Y / N	May we call you at work? Y / N
May we leave a message at home? Y / N	May we leave a voicemail at work? Y / N
May we mail you information at home? Y / N	

What concerns or issues convinced you to seek assistance now? _____
_____
_____

3. Grade _____
Were any grades skipped? Yes / No
Were any grades repeated? Yes / No Which ones? _____

4. Father's Name:_____ Occupation:_____

5. Mother's Name:_____ Occupation:_____
Other legal guardians: _____

6. Who else lives in the home? (Please include name, relationship to the child, age of brothers/sisters or other children.)
_____
_____
_____

7. Emergency Contact Person:_____
Emergency Contact Phone #:_____
Relationship to child: _____

8. Is the child adopted? Yes/No If so, at what age? _____

9. Are there close family members not living in the home? **Yes / No** (Biological/step parents or siblings; list name, relationship to the child, age of brother/ sister(s) or other children)
_____
_____

10. Mother's health during pregnancy: _____ Good _____ Fair _____ Poor
If fair or poor, please describe: _____
_____

11. During pregnancy; did the mother:

Take any medications? Yes / No	If yes, please list
Drink Alcohol? Yes / No	If yes, how much?
Smoke Cigarettes? Yes / No	If yes, how much?
Use recreational drugs? Yes / No	What and how much?

12. Length of pregnancy: _____ Birth weight: _____

- Duration of labor:_____Were forceps used? Yes ☐ No ☐
- Delivery was (check one) _____ Normal, _____ Breech, _____ Cesarean
- Were there any problems before or after delivery?Yes ☐ No ☐

If so, please describe: _____

13. Is your child on any medications? Yes ☐ No ☐ Prescribed by:_____

If so, what is the medicine, the dosage and how long has your child been on it?

_____

To your knowledge has your child tried any of the following?

- Tobacco: Yes ☐ No ☐
- Alcohol: Yes ☐ No ☐
- Street or Recreational Drugs: Yes ☐ No ☐
- Over the Counter Drugs : Yes ☐ No ☐

If yes please name_____

Does your child have any medical problems: Y ☐ N ☐

If yes, please describe: _____

Has your child ever been hospitalized Y ☐ N ☐

If so, when and why? _____

Has your child received any previous counseling or Mental Health Treatment? Y ☐ N ☐

(Please specify) _____

Last Physical: _____ Child Height: _____ Weight:_____

Name of primary care physician? _____

14. As well as you can remember, were there any delays in the following areas?

Sat alone	Y / N	Toilet Trained	Y / N	Buttoned Clothes	Y / N
Named colors	Y / N	Crawled	Y / N	Said Words	Y / N
Rode bike	Y / N	Said alphabet	Y / N	Tied shoes	Y / N
Stood along	Y / N	Used sentences	Y / N		
Began to read	Y / N	Walked alone	Y / N		

15. Is there a family history of mental health problems? Yes No
Please specify: _____

Is there a family history of Substance Abuse? Yes No
Please specify: _____

16. Is there a history of, or current concern with any of the following (please check). For each item checked, please list how long these have been problems.

_____ School Behavior Problems	_____ Academic/Special Education
_____ Eating problems	_____ Stealing
_____ Speech Difficulties	_____ Masturbation
_____ High temperatures	_____ Runaway
_____ Head injuries/concussions	_____ Temper tantrums
_____ Poor memory	_____ Crying spells
_____ Wetting pants	_____ Cruelty to animals
_____ Soiling pants	_____ Coordination
_____ Lying	_____ Truancy
_____ Avoids cuddling	_____ Impulsivity
_____ Sleep difficulties	_____ Interrupting
_____ Headaches	_____ Poor attention
_____ High energy	_____ Bed wetting
_____ Constipation	_____ Fire setting
_____ Sex play with other children	_____ Frequent bad dreams
_____ Aggressive behavior	_____ Defiance to authority
_____ Legal problems	_____ Obsessive Behavior
_____ Fears	_____ Suicidal thoughts
_____ Attention Deficit Disorder	_____ Hallucinations
_____ Bizarre Behaviors	_____ Other

17. What stressors are affecting your child?
Home _____ Parent Conflict _____
Peer _____ Family _____
School _____ Siblings/Step _____
Grades _____ Step Parent _____
Other _____ Losses _____

18. How does your child get along with other children (Please Check)

	Good	Fair	Poor
School			
Home			

Do you have any concerns about their friends? Yes ☐ No ☐

19. What does your child and family do for fun? (Please Check)
Games: _____ Outing: _____ Movies: _____ Sports: _____ School Functions: _____ Other: _____

20. What are your child's assets? (Please Check)
Academics: _____ Music: _____ Art: _____ Sports: _____ Helpful: _____
Good-natured:_____ Plays well with others: _____ Cooperative: _____
Other: _____
_____