



**CHILD AND ADOLESCENT
MEDICAL/DEVELOPMENTAL HISTORY**

Please complete the following questionnaire as thoroughly as possible.

Child's Name: _____ Age: _____

Birth Date: _____ Gender: _____

Race/Ethnicity/Cultural Identity: _____ Today's Date: _____

This form was completed by: _____

Relationship to child: _____

Child's Home Address: _____

Child's Legal Guardian(s): _____

Relationship(s) to Child: _____

Guardian's Address: _____

Guardian's Phone Number: _____ Guardian's email: _____

Are current caregivers different from legal guardians: Yes No

If yes, name of current caregiver(s): _____

Relationship(s) to child: _____

Are there currently any custody disputes about the child? Yes No

If yes, please explain: _____

Child's School: _____ Grade: _____

Child's Teacher: _____ School Phone: _____

Child's Teacher's email: _____

Presenting Concerns

1. Please list three main concerns you have about your child:

a.

b.

c.

2. How long ago did your child's problems begin? _____

3. Were there any important events that happened at about the same time that your child's behavior changed?
4. What do you think contributed to the problems?
5. What have you tried to do to help your child with the problems and how has this worked?

Family Background

6. Below, list all of the people with whom your child is currently living, their relationship to your child (e.g., mom, stepfather, sister, adopted brother, etc.), and describe what that relationship is like.

<i>Name</i>	<i>Age</i>	<i>Relationship to your child</i>	<i>How well does your child get along with them?</i>

7. Below, please list all family members (parents, siblings) living outside of the home and briefly describe why they are not in the home.

<i>Name</i>	<i>Relationship to your child</i>	<i>Why are they living out of the home?</i>

8. Please list others whom you feel have an important impact on your child's life:

9. Has your child ever shared a room with anyone? Yes No

If yes, please specify

<i>Name of person</i>	<i>Age</i>	<i>Relationship to child</i>	<i>From</i>	<i>Until</i>

10. Please provide details about your child's parents/step-parents/caregivers:

<i>Name</i>	<i>Age</i>	<i>Living</i>	<i>Occupation</i>	<i>Health</i>
		Yes No		

11. If your child lives in more than one residence, please describe the visitation arrangements:

12. List the dates of marriages and divorces of the child's parents, including current:

<i>Parent's Name</i>	<i>Date of Marriage</i>	<i>Date of Divorce</i>

13. Who supervises your child when the primary caregivers are at work? (Check all that apply)

- Day care center
 Private Sitter
 Child Stays by him/herself
 Relative
School
 Other (please specify) _____

14. Has your child ever lived outside of the home (for example, in foster care, with relatives)?
 When? _____ With whom? _____

15. Has your child experienced or witnessed any of the following? If yes, please explain.

- Physical abuse (i.e., either by an adult or peer)

Sexual molestation, sexual abuse

- Death of parent, sibling, or other close relative
- Removal from the home
- Alcohol or drug abuse by a caregiver or sibling
- Witnessed violence or abuse of others in the home
- Criminal arrest and/or court proceedings (e.g., juvenile arrest, custody dispute)
- Serious illness or disability, either the child or in a close relative
- Separation from one or more caregivers for an extended period of time
- Other situations that may have been traumatic

Developmental History

16. Did the mother receive prenatal care? Yes No
17. Age of biological mother when pregnant with this child _____ Age of biological father _____
18. Did biological mother take medications while pregnant? Yes No
 If yes, explain: _____
19. Was there any prenatal substance exposure? If so, give frequency and amount used.
- Alcohol _____
 - Cannabis _____
 - Cocaine _____
 - Heroin/prescription opioids _____
 - Nicotine/tobacco _____
 - Other _____

20. Complications of pregnancy (check all that apply):

- None Diabetes High blood pressure
Breech birth Cesarean section Toxemia
Jaundice Poor emotional health Mother's loss of consciousness
Difficult Birth Other: _____

21. Was the baby born prematurely? Yes No

If yes, how many weeks early? _____

22. Did the baby need special medical help at birth? For example, did the baby have trouble breathing during or shortly after birth, or was there a need for NICU care? Yes No

If yes, please explain: _____

23. Did the mother have any complications at birth? Yes No

If yes, please explain: _____

24. How much did the baby weigh at birth? _____

25. Did the baby have birth defects? Yes No

If yes, please explain: _____

26. Did the baby have medical problems during the first year? Yes No

If yes, please explain: _____

27. Feeding problems (check all that apply)

- None Colic Diarrhea Vomiting Spasms
Constipation GERD Reflux Overeating
Other (please explain) _____

28. How did the baby sleep during the first few months? _____

29. Who was the baby's main caretaker? _____

30. The baby was (check all that apply):

- Cranky Difficult Calm Persistent
Overly active Social Shy Curious
Hard to please Easy Demanding Sleepy/Slow-moving
Hard to cuddle Alert Head-banging Happy

31. At what age did your child first do the following?

Age	Age	Age
_____Crawl	_____Understand first words	_____Toilet-trained
_____Stand Alone	_____Speak first words	
_____Walk Alone	_____Speak in Sentences	

32. Did a pediatrician ever voice concerns about a developmental delay? Or did your child receive a low score on a developmental screen? Yes No

If yes, please explain: _____

33. Did bed-wetting or bed soiling occur after toilet training? Yes No

If yes, please describe: _____

34. Did your child require any intervention services, such as First Steps, special education at an Early Childhood Center, or through a private service provider? Yes No

If so, at what age? _____ Please mark all services received.

PT (Physical Therapy) OT (Occupational Therapy)

Speech/Language Social/Emotional/Behavior

35. Has your child had difficulty with any of the following speech/language skills? (Check all that apply)

Pronouncing words correctly

Understanding what is being said

Using words correctly in a phrase or sentence

Stuttering (please describe: _____)

Trouble expressing needs (please describe: _____)

36. Has your child had difficulty with any of the following problems? Check all that apply and explain.

Abnormal height or weight _____

Night Terrors _____

Sleepwalking _____

Toileting accidents _____

- Nail-biting _____
- Skin-picking _____
- Unusual fears _____
- Sleep problems _____
- Hair-pulling _____
- Eating problems _____
- Sleep Problems _____
- Other _____

37. At what age did your child show curiosity about sex? _____
 Describe the nature of questions and how this was handled

38. At what age did your child begin puberty? _____
 Describe any concerns: _____

Medical History

39. Name of your child's physician: _____
 Date of last physical: _____

40. Please list any other doctors your child sees (specialists, etc

41. Please list below dates and reasons for any operations and hospitalizations

<i>Operation/Hospitalization</i>	<i>Age at Time</i>	<i>Problems/Aftereffects</i>

42. Is your child up-to-date on immunizations? Yes No
 If no, please explain: _____

43. Please indicate if your child has experienced any of the following and the age at which they were experienced:

			Age
<input type="checkbox"/> Vision problems (wears glasses, etc.)			_____
<input type="checkbox"/> Hearing problems (hearing aids, etc.)			_____
<input type="checkbox"/> Chronic ear infections			_____
<input type="checkbox"/> Coordination problems (running, throwing, writing)			_____
	Age		Age
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Gall Bladder	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> German Measles	_____
<input type="checkbox"/> Appendicitis	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart Murmur	_____
<input type="checkbox"/> Blood Clots	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Blood Pressure	_____	<input type="checkbox"/> High Fevers	_____
<input type="checkbox"/> Broken Bones	_____	<input type="checkbox"/> HIV	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Hives	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> COVID	_____	<input type="checkbox"/> Liver Trouble	_____
<input type="checkbox"/> Dental	_____	<input type="checkbox"/> Lockjaw/Tetanus	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Meningitis	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Fainting/Dizzy	_____	<input type="checkbox"/> Pneumonia	_____
		<input type="checkbox"/> Polio	_____
		<input type="checkbox"/> Rheumatic Fever	_____
		<input type="checkbox"/> Scoliosis	_____
		<input type="checkbox"/> Seizures/Epilepsy	_____
		<input type="checkbox"/> Sickle Cell	_____
		<input type="checkbox"/> Sinusitis	_____
		<input type="checkbox"/> Skin Rashes	_____
		<input type="checkbox"/> T.B.	_____
		<input type="checkbox"/> Thyroid	_____
		<input type="checkbox"/> Tics	_____
		<input type="checkbox"/> Tonsilitis	_____
		<input type="checkbox"/> Typhoid Fever	_____
		<input type="checkbox"/> STIs	_____
		<input type="checkbox"/> Whooping Cough	_____
		<input type="checkbox"/> Other _____	_____

For anything marked above, please explain:

44. Please list below any illness/long-term medical conditions.

<i>Illness/Persistent Condition</i>	<i>Age of Onset</i>	<i>Treatment</i>

45. Has your child ever had a head injury, fainted, or lost consciousness? Yes No
 If yes, please explain. Please include the age of your child when this occurred.

46. Please list below any serious accidents/falls that your child has experienced.

<i>Accident/Fall – what happened</i>	<i>Age at Time</i>	<i>Treatment and Aftereffects</i>

47. Please list below any medications that your child is currently taking.

<i>Medication</i>	<i>Dose</i>	<i>Prescriber</i>	<i>Reason Prescribed</i>	<i>Side Effects</i>

Does your child take the medication(s) regularly/reliably? Yes No

Mental Health History

48. Have you sought mental health treatment (e.g., therapy, counseling, psychiatry) for your child before? Yes No

If yes, please list the professional, dates seen, reasons for treatment, and reason treatment was discontinued (e.g., symptoms resolved, finances, etc.).

<i>Name of Mental Health Professional</i>	<i>Dates Seen</i>	<i>Reason for Treatment</i>	<i>Reason Discontinued</i>

49. Has your child ever received a mental health diagnosis (e.g. Major Depressive Disorder, Generalized Anxiety Disorder, ADHD, etc.) Yes No

If yes, please list below.

<i>Diagnosis</i>	<i>Diagnosing Provider</i>	<i>Date</i>

50. Has your child ever been hospitalized for a psychiatric condition? Yes No

If Yes, please list hospitalizations and reason/dates below.

<i>Name of Hospital</i>	<i>Dates Seen</i>	<i>Reason for Hospitalization</i>

51. Please indicate if anyone in your child's family has experienced any of the following conditions. Check the item and then state their relationship to your child.

Condition

Indicate who (e.g., child, mother, brother, etc.)

- ADHD/ADD _____
- Alcohol Abuse _____
- Anorexia/Bulimia _____
- Anxiety/Nervousness _____
- Autism _____
- Bipolar Disorder/Manic Depression _____
- Dementia _____
- Depression _____
- Drug Abuse _____
- Growth Problems _____
- Intellectual Disability _____
- Physical disability (e.g., blindness, hearing loss, loss of limb) _____
- Schizophrenia _____
- Seizures/convulsions/Epilepsy _____
- Self Harm _____
- Specific Learning Disorder _____
- Sudden Death _____
- Suicide Attempt _____
- Other illness, please explain _____

Academic History

52. Did your child attend nursery school/preschool? Yes No If yes, at what age? _____
Describe any problems your child had:

53. How old was your child when they first went to an out-of-the-home "school program"? _____

61. Has your child received special education services or other academic supports?

Yes No If yes, please explain below.

<i>Why</i>	<i>For what type of class</i>	<i>Grade(s)</i>

62. Has your child ever been suspended or expelled? Yes No If yes, please explain:

<i>Grade</i>	<i>Why</i>

63. Does your child do homework regularly? Yes No

On average, how long does your child spend on homework each night? _____

Who helps your child with homework if help is needed? _____

Legal History

64. Is your child now or have they ever been involved with the juvenile justice system

(including police reports, charges, arrests, probation, etc.)? Yes No

If yes, at what age and why?

65. Is your child or an immediate family member involved in any lawsuits or other legal issues

at the present time? Yes No

If yes, please explain: _____

66. Does your child currently have an assigned DJO (Deputy Juvenile Officer), GAL (Guardian ad Litem), CASA (Court-Appointed Special Advocate) or other court representative?

Yes No If yes, give name and contact information:

Social History

67. Is your child able to care for him/herself (dress, eat, hygiene, making change, telling time, using phone) in a manner appropriate for his/her age? Yes No

If no, please explain:

68. Please list the activities, extracurriculars, and special interests that your child most enjoys.

Has your child's interest in these activities changed recently? Yes No

If yes, explain: _____

69. Compared to other children the same age, how well does he/she do these activities?

Poor Fair Average Very Well

70. Compared to other children of the same age, how much time does your child spend in these activities? _____

71. Please list any organizations, clubs, teams, or groups your child belongs to and describe how active they are in these:

72. Please list any jobs your child has (for example: paper route, babysitting, fast food). Also, please describe how well they carry out these jobs:

73. Please list any chores your child has (for example: make bed, feed pets, clean room). Also, please describe how well they carry out these chores:

74. Who usually disciplines your child? _____

What methods are used? _____

Which seems most effective? _____

75. How do you reward your child? _____

76. Does your child prefer to play with others or alone? With others Alone

What activities, if any, does your child enjoy with other children?

What activities, if any, does your child enjoy when playing alone?

77. Please describe your child's use of social media:

78. Does your child play better with younger peers, same-aged peers, or older peers?

- Younger Same age Older

79. How well does your child get along with other children?

- Poor Fair Average Very Well

80. Has your child experienced or perpetrated any bullying? Yes No

If yes, please explain:

81. Please describe your child’s interactions with peers: No social concerns

- No friends Few friends Mean, aggressive Bossy, controlling
 Loses friends Too shy, timid Trouble making friends

82. Does your child engage in risky behavior (e.g., substance use, unsafe sex, getting into dangerous household products, unsafe driving, etc.)? Yes No

If yes, please explain: _____

Substance used (type/frequency): _____

83. Do any of your child’s friends engage in risky behavior (e.g., smoking, drinking, drug use, unsafe sex, involvement with police)? Yes No

If yes, please explain: _____

84. What, if any, religious denomination is your child? _____

How often do they attend religious services? _____

85. Please state whether the family has relocated, moved residence, or significantly changed lifestyle due to job or health-related factors such as promotions, unemployment, acute or chronic illness in family, military service, etc.:

86. List the individual, groups, or agencies you are involved with that relate to this child and their problems (e.g., church or church group, PTA, AA, Division of Family Services):

87. What do you see as your child’s strengths?

88. What do you see as your child’s weaknesses?

Please add any other information below that you feel is important in understanding your child.

Thank you for taking the time to complete this form.