Brief Developmental History for Juveniles

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

1. Child's Name:_____ Birthdate:_____
   Sex:_____ Age:_____

2. Home Telephone: _____ Parents Work No.:_____

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 voicemail you 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 Number:_____

   Relationship to child:_____

Child's Name:_____

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/s sisters 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	Please List:
Drink Alcohol?	Yes	No	How Much?
Smoke cigarettes?	Yes	No	How Much?
Use recreational drugs?	Yes	No	What/how much?

12. Length of pregnancy:_____ Birthweight:_____
Duration of labor:_____ Were forcepts 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: ☐ Yes ☐ No

If yes, please describe:_____

Child's Name:_____

Has your child ever been hospitalized: ☐ Yes ☐ No
if so, when and why?_____

Has your child received any previous counseling or Mental Health Treatment?
(Please specify) ☐ Yes ☐ No

Last Physical:_____ Child height:_____ Weight:_____
Name of primary care physician?_____
Health Insurance – Please Identify:_____

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

	Yes	No		Yes	No
Sat alone	☐	☐	Toilet Trained	☐	☐
Named colors	☐	☐	Crawled	☐	☐
Rode bike	☐	☐	Said alphabet	☐	☐
Stood along	☐	☐	Used sentences	☐	☐
Began to read	☐	☐	Walked along	☐	☐
Buttoned clothes	☐	☐	Tied shoes	☐	☐
Said words (besides mama, dada)	☐	☐			

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

Is there a family history of Substance Abuse in your family? ☐ **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	_____	Cruel to animals
_____	Soiling pants	_____	Coordination
_____	Lying	_____	Truancy

_____	Avoids cuddling	_____	Impulsivity
_____	Sleep difficulties	_____	Interrupting
_____	Headaches	_____	Poor attention
_____	High energy	_____	Bed wetting

Child's Name_____

_____	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-natures:_____
Plays well with others:_____ Cooperative:_____
Other:_____

21. Please make any other comments what may be helpful in understanding your child: