Bryn Mawr Psychological Associates

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DEVELOPMENTAL HISTORY

(All information is kept strictly confidential and will not be released to anyone without your permission.)

Child's name: _____ Date of Birth: _____ Age: _____

School: _____ Grade: _____ Today's date: _____

Name of person completing this form: _____

WHAT ARE YOUR MAIN REASONS FOR SEEKING TREATMENT FOR YOUR CHILD/FAMILY?

1.

2.

3.

FAMILY INFORMATION

Parent's name: _____ Age: _____ Education: _____ Occupation: _____

Parent's name: _____ Age: _____ Education: _____ Occupation: _____

Parent marital status (include current and prior marriages, years married, names of step-parents):

If separated/divorced, please describe custody arrangement/visitation schedule:

Child's siblings:	Name	Age	Where living?
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Others living in the home: _____

Pets: _____

CHILD'S MEDICAL HISTORY

Current medical problems:

Current medications:

Prior psychiatric medications:

History of other significant medical problems and operations:

Any history of: Concussion: Yes / No Seizures: Yes / No Facial tics: Yes / No

Child's Prior Psychological/Psychiatric History:

Provider: _____ When: _____

Reason: _____ Why stopped? _____

Provider: _____ When: _____

Reason: _____ Why stopped? _____

Provider: _____ When: _____

Reason: _____ Why stopped? _____

BIRTH HISTORY (circle one)

Child: Biological / Adopted / Foster

Delivery: Vaginal / Caesarian

Length of Pregnancy: Full-term / Premature (How early? ____)

Medical problems/complications at delivery:

How long was your child in the hospital?:

DEVELOPMENTAL HISTORY (circle one)

Sitting alone	early / on time / late	
Walking alone	early / on time / late	
First words	early / on time / late	
Language development	early / on time / late	
Speech therapy	Yes / No	
Physical therapy	Yes / No	
Occupational therapy	Yes / No	
Significant separation problems	Yes / No	Comments: _____
Sleep problems	Yes / No	Comments: _____
Eating problems	Yes / No	Comments: _____
Fine motor skill problems	Yes / No	
Gross motor skill problems	Yes / No	

Toilet training (completed at what age: _____)

Briefly describe any difficulties:

Please describe child care history (e.g., at home, day care, preschool with extended day, etc.):

CHILD'S TEMPERAMENT (Check all time frames that apply)

	First year of life	This year	Ongoing issue over the years	Comments
Difficult to comfort	_____	_____	_____	_____
Sleep problems	_____	_____	_____	_____
Fussy/irritable	_____	_____	_____	_____
Unhappy	_____	_____	_____	_____
Lack of affection	_____	_____	_____	_____
High-energy	_____	_____	_____	_____
Shy/cautious	_____	_____	_____	_____

CHILD'S SOCIAL DEVELOPMENT

Please describe your child's social behavior at school:

Please describe your child's behavior with siblings (if applicable):

Please describe your child's behavior with friends/peers around home:

What activities does your child enjoy?

Religion: _____ Actively involved?: _____

STRENGTHS

Please describe your child's strengths:

CHILD'S ACADEMIC HISTORY

Current school: _____ Grade: _____

Address:

Phone:

Name of teacher:

Name of guidance counselor:

(*Note: No contact is made by us with school staff without your permission and request.)

	(circle one)
Math	Delayed / On target / Advanced
Reading	Delayed / On target / Advanced
Spelling	Delayed / On target / Advanced
Any grades repeated?	Yes / No
Special Education Classes?	Yes / No
Tutoring?	Yes / No

Does your child have an IEP plan? _____ (If yes, please bring a copy to the initial evaluation)

Does your child have a 504 plan? _____ (If yes, please bring a copy to the initial evaluation)

Has your child had a Psychological Evaluation? _____ (If yes, please bring a copy to the initial evaluation)

Please indicate any problems reported by teachers this year:

Please indicate any significant problems reported by teachers in prior years:

FAMILY HISTORY

A review of family history is often very helpful in a thorough evaluation. Please think about parents, siblings, grandparents, aunts/uncles, and cousins as you fill in the chart below. Include if you know if someone is taking a psychoactive medication (e.g., sister taking anti-anxiety medication).

Family Mental Health History		
Check the item if you think a family member has or had the problem. Indicate relation to child in the final column (e.g., paternal uncle or maternal grandfather).		
Illness or Problem	**X**	**Relation to child**
Attention Problems or "ADD"		
Hyperactivity or "ADHD"		
Significant Anger problems		
Learning Disability		
Tics or Tourette's Disorder		
Special education services		
Mental Retardation		
Autism/Asperger's Disorder		
Takes Psychiatric Medication		
Depression		
Manic Depressive or Bipolar Disorder		
Schizophrenia		
Suicide or Suicide Attempts		
Deliberate Self-Harm		
Psychiatric Hospitalization		
Obsessive/Compulsive problems		
Anxiety/Fears/Phobias		
Panic Attacks		
Eating Disorder (Anorexia/Bulimia)		
Significant Sleep Problems		
Alcoholism		
Drug Abuse		
Survivor of Abuse		
Post Traumatic Stress Disorder		
Violent or Abusive Behavior		
Trouble with the Law		
Other:		