

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 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: 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	<input type="checkbox"/>	<input type="checkbox"/>	Toilet Trained	<input type="checkbox"/>	<input type="checkbox"/>
Named colors	<input type="checkbox"/>	<input type="checkbox"/>	Crawled	<input type="checkbox"/>	<input type="checkbox"/>
Rode bike	<input type="checkbox"/>	<input type="checkbox"/>	Said alphabet	<input type="checkbox"/>	<input type="checkbox"/>
Stood along	<input type="checkbox"/>	<input type="checkbox"/>	Used sentences	<input type="checkbox"/>	<input type="checkbox"/>
Began to read	<input type="checkbox"/>	<input type="checkbox"/>	Walked along	<input type="checkbox"/>	<input type="checkbox"/>
Buttoned clothes	<input type="checkbox"/>	<input type="checkbox"/>	Tied shoes	<input type="checkbox"/>	<input type="checkbox"/>
Said words (besides mama, dada)	<input type="checkbox"/>	<input type="checkbox"/>			

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: