Cognitive Renewal, Inc.,
a Licensed Clinical Social Worker

EXTENSIVE CHILD AND ADOLESCENT DEVELOPMENTAL HISTORY

Completed By:_____ Date:_____

Child's Name: _____ Age:_____ Birthdate:_____
Grade:_____ School:_____

Family Members	Age	Education	Occupation/School
Mother			
Father			
Stepmother			
Stepfather			
Siblings:			

Other Family Members:

_____

_____

STRENGTHS: Please identify three strengths of your child.

_____

_____

_____

CONCERNS: What are the child's presenting symptoms/behaviors as you see them?

_____

_____

_____

How long have you been witnessing these behaviors?

_____

_____

Please complete the following information to the best of your knowledge. If you're not sure, make a guess and put a question mark after it.

EARLY HISTORY

Pregnancy and Delivery: How many pregnancies has the child's mother had? _____ Miscarriages? _____ Number of children born alive? _____ Number of stillborn children? _____ Abortions? _____ Problems with infertility? _____

Parents attitude toward pregnancy:_____

Are parents the child's birth parents? _____ If not, please explain, e.g., adoption, step parent, foster parent)_____

Describe the mother's pregnancy with this child:_____

_____

Describe any pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.):_____

_____

S/he weighed _____ lbs _____ oz. at birth. S/he was born early by two weeks or more _____; at 9 months _____; overdue by two weeks or more _____.

Describe the child's delivery:_____

_____

Describe the child's temperament during infancy:_____

_____

Primary caretaker(s) for child, first year:_____
Age 1-3:_____ Thereafter:_____

Check any problem areas:	First week of life	First three months	First year	Age 2-5 years
Feeding/eating problems	____	____	____	____
Sleeping problems	____	____	____	____
Ear infections	____	____	____	____
Weight gain too fast or too slow	____	____	____	____
Excess crying	____	____	____	____

Breathing/oxygen problems ____ ____ ____ ____
Bowel problems ____ ____ ____ ____

Mother's health after delivery:_____

Post-delivery blues? _____ If yes, how long? _____

DEVELOPMENTAL MILESTONES:

To the best of your recollection, at what age did your child: sit alone _____; crawl _____; walk alone; ride a two-wheeled bike _____; current level of activity:_____

When did your child say several words besides mama, dada _____, name several objects (ball, cup) _____; use sentences of 3 or more words _____? Any current problems in language development?_____

When did your child first smile _____; show shyness with strangers _____; separate from mother easily _____: engage in cooperative play with others _____.

Describe toilet training:_____

_____

Age bowel control achieved: day _____ night _____
Age bladder control: day _____ night _____
Any problems currently?_____

Does your child have difficulty with fine motor control (e.g., writing, drawing)?_____
Does s/he have difficulty with gross motor control (e.g., clumsiness in riding a bike, playing ball? _____

Does your child lose his or her balance easily? _____

Any problems with speech?_____

Does your child have difficulty remembering things?_____

HEALTH:

How would you rate your child's health? Poor Fair Good Excellent

Is the child allergic to anything? Yes _____ No _____ If so, what?_____

List child's hospitalizations or surgery

Age	Year	Reason	Reaction

Separations from mother and/or father: age, duration, reaction to:

Has the child had any of the following?

____	Mumps	____	Head injury	____	Blueness (cyanosis)
____	Chicken pox	____	Trouble seeing	____	Fainting spells
____	German measles	____	Been unconscious	____	Tiring easily
____	Whooping cough	____	Blood transfusion	____	Seizures
____	Pneumonia	____	Anemia	____	Ear infections
____	Asthma	____	Easy bruising	____	Mouth breathing
____	Blood in urine	____	Urine/kidney infection	____	Snoring
____	Broken bones	____	High blood pressure	____	Trouble hearing
____	Other_____				

Sleep behavior (sleepwalking, nightmares, recurrent dreams, current problems including getting up, going to bed):_____

_____

Name of child's physician:_____

Date of last medical/physical exam:_____

Medications and dosages currently used (including vitamins, if any):

_____

Does your child wear glasses? _____ Has your child had a hearing exam?_____

SCHOOL HISTORY: List all schools the child or teenager has attended, including preschool:

Age	Grade(s)	Dates	School	Location

Best school subjects:

Most difficult subjects:

Concerns of the school regarding child:

Does your child have any learning problems? Explain:

Has your child had previous psychological testing? Date: By:

Have any other members of the family or relatives had learning problems?
Please describe:

FAMILY INFORMATION:

Note age of child and date of important events (for example, change of residence, birth of sibling, death of relative, friend, parent separation, divorce, etc.):

Age	Date	Event	Reaction

Languages other than English spoken at home:_____

Health of Family Members

Condition	Relationship	Condition	Relationship
_____ Asthma	_____	_____ Rheumatic fever	_____
_____ Dermititis/skin problems	_____	_____ High blood pressure	_____
_____ Allergies	_____	_____ Kidney (urine) problems	_____
_____ Seizures	_____	_____ Cancer	_____
_____ Diabetes	_____	_____ Childhood deaths	_____
_____ Retardation	_____	_____ Behavioral or emotional problems	_____
_____ Physical or sensory impairments	_____	_____ Depression	_____
_____ Learning disabilities	_____	_____ Alcohol or drug use/ dependency	_____
_____ Tuberculosis	_____	_____ Obesity, anorexia or bulimia	_____
_____ Anemia	_____	_____ Other (specify)_____	_____
_____ Thyroid problems	_____	_____	
_____ Heart disease	_____		

SOCIAL AND EMOTIONAL HISTORY:

What are the child's major play activities?_____

_____

Describe special interests and hobbies:_____

_____

_____

Does your child prefer to play alone?_____ With other children?_____

With younger children_____ With older children?_____ With same-age children?_____

Does your child play easily with other children?_____ Please describe_____

_____

How would you describe your child's disposition, temperament, behavior?_____

_____

_____

_____

_____

_____

How does your child get along with:

Parents:_____
Siblings:_____
Peers:_____
Teachers:_____

Are you currently having any trouble managing your child's behavior?_____ If so, please describe_____

_____

Has your child or other family members had any counseling or therapy?_____ If so, please describe_____

_____

How does your child express anger?

What kinds of discipline are used at home?

What seems most effective?

Any nervous habits the child has now or has had in the past?

Any fears which the child has now or has had in the past?

Please use this page to add any information or feelings which have been weighing on your child's mind:

What questions do you have that you would like addressed in this evaluation?