Lynn Schiller LLC
47 Maple Street
Suite L-9
Summit, NJ 07901
973-410-8596

Developmental History & Background

Patient's name:____________________________
Date of birth:__________
Today's date:__________
Name of person completing form:______________________________
Relationship to patient:_____________________

Family Members:

Father's Name:___________________ Date of Birth:_________
Last Grade Completed:_____________
Occupation:______________________
Employer:________________________

Mother's Name:___________________ Date of Birth:__________
Last Grade Completed:______________
Occupation:_______________________
Employer:________________________

Are Mom and Dad Still Married?______

Siblings: (names, gender, dates of birth)

Others Living In the Household:

Family Medical History:

____diabetes
____thyroid problems
____heart disease
____hypertension
____allergies
____cancer
____asthma
____tuberculosis
____epilepsy
____learning disabilities
____mental retardation
____attention difficulties
____anxiety
____obsessions/compulsions
____alcoholism
____drug use
____depression
____other medical/mental conditions

Please elaborate on any checked items above:

Pregnancy:

Is your child adopted?_______
If you answered yes above, please describe the biological mother's pregnancy (include any complications):

Please check if any of the following occurred:
____toxemia ____Rh factor incompatibility ____breech
____eclampsia ____hypertension

Please check and indicate the frequency of use during pregnancy if applicable:

____Beer or Wine__________
____Hard Alcohol__________
____Coffee or Caffeinated Beverages_________
____Cigarettes_________
____Marijuana_________
____Other________

Please check and indicate the frequency of use during pregnancy if applicable:

____Valium (Xanax, Librium)
____Tranquilizers
____Seizure Medication
____Antidepressants
____Antibiotics
____Sleep Medication
____Other__________

Pregnancy Questions:

Was you child full-term?_______

Please describe your labor and delivery (complications, medications, etc.):

Describe your child's condition at birth (height, weight, APGAR scores, etc.):

Child's Infancy:

Describe your child as an infant (easy, difficult, etc.):

Response to touch and cuddling:

Eating behaviors:

Was your child colicky?:
Sleeping behaviors / routine (including naps and nighttime):

Describe how alert your infant was:

Was your infant sociable with others, fearful of others:

Was it easy to set and follow routines with you child as an infant:

Describe your infant's activity level as an infant/toddler:

Describe any health problems during infancy:

List age of the following developmental milestones and any notable details:

____smile____
____rolling over____
____sitting without support______________________________
____crawling____
____grasping objects_____________________________________
____walking____
____toilet trained_______________________________________

Describe your child as a toddler (easy or difficult, energetic, inquisitive, defiant, independent, clingy):

Language Development:

Describe your child's speech and language:

At what age did your child understand spoken words?______________________
When did your child say his/her first word?___________________
At what age did your child begin combining two and three words together?__________
Does your child have difficulty organizing his/her ideas?________________
If yes to above, how so?____
Can he/she retell a story in logical order?_________

Describe any developmental concerns:

Medical History:

Describe your child's general health:

Does your child have any hearing or vision problems (if so please describe):

Describe your child's gross (running, biking, sports) and fine (writing, tying shoes, handling small objects) motor coordination:

Does your child have any chronic health problems (asthma, diabetes, heart condition)?:

Please note if you child has had any of the following condition and at what age:

____Mumps____________
____Measles____________
____Scarlet Fever________
____Pneumonia__________
____Otitis Media_________
____Seizures_____________
____Other:_______________

____Chicken Pox____________
____Whooping Cough________
____Rubella_________________
____Encephalitis_____________
____Lead Poisoning___________
____Allergies________________

Has your child received his/her vaccinations/immunizations?:

Describe any accidents or falls your child has had:

Describe any hospitalizations or surgeries your child has had:

<u>School History:</u>

At what age did your child start kindergarten:_________
Was he/she in daycare? If so from what ages?:________
Has your child ever skipped grades? If yes, which ones?:________

In the spaces below describe your child's adjustment to school, interests in school, and any strengths or weaknesses. Please note the name of the school and years the child attended the following:

Preschool:

Kindergarten:

Grades 1-3:

Grades 4-6:

Junior High School:

High School:

Describe any academic subjects that are difficult for your child:

Has he/she ever been evaluated by a Child Study Team? Was a classification recommended or were any accommodations made, if yes what were they?:

Social Development:

Describe what your child is like at home (activity level, behavior, ability to entertain self, relationships):

How easily does your child make friends? Do these friendships last?:
Does your child have many friends? Are they the same age or younger?:

How well does your child get along with his/her friends?:

What are your child's interests and hobbies? Any special skills? Sports?:

Treatment History:

Has your child ever been referred to counseling or other psychological services before? What were the presenting problems? What was the outcome of treatment?:

Current Concerns:

Describe the primary concerns that led you to treatment for your child at this time:

When did these issues begin and how severe are the problems?:

If your child aware of your concerns? Is so how would he/she describe the problem?:

When you need to set limits with your child or when he/she does not follow the rules, what intervention strategies have you found to be effective?:

Do you have concerns about alcohol or drug use with your child?:

Any concerns about eating disorders with your child?:

Have there been any important events (divorce, death, illnesses, accidents) in your family that may be affecting your child's emotional health or school performance?:

What would be the most difficult adjustment in your child's life to date?: