Psychotherapy Services of CT, L.L.C.
Vernon, CT 06066

Child and Adolescent Developmental History

Please fill out this information form as completely as you can. Also, **circle** the item number of any questions that should be discussed more fully.

Child's Name _____ Sex _____ DOB _____
Grade _____ School _____
Your Name _____ Relationship to Child _____

Family Members

	Name	Age	In Home	Occupation/Grade
Parents	_____	____	_____	_____
	_____	____	_____	_____
Siblings	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____
Others	_____	____	_____	_____
	_____	____	_____	_____

Is the child adopted? _____ Yes _____ No

Does your child have any current problems at school and/or home? _____
_____

Please list any previous counseling and/or treatment that your child has had, including dates:
_____
_____

1. What is your child like? Check all that apply:

___ Impulsive	___ Easily frustrated	___ Shy	___ Dependent	___ Relaxed
___ Affectionate	___ Cannot ask for help	___ Unhappy	___ Private	___ Outgoing
___ Sensitive	___ Often in trouble	___ Enthusiastic	___ Immature	___ Quiet
___ Independent	___ Often tearful	___ Tense	___ Distractible	___ Helpful
___ Depressed	___ Rapid mood changes	___ Happy	___ Irritable	___ Friendly
___ Disorganized	___ Lacks confidence	___ Demanding	___ Restless	___ Angry
___ Aggressive	___ Very active	___ Bossy	___ Stubborn	___ Fearful

2. How does your child get along with his/her parents? _____
_____

3. a. Are there any parent or family conflicts? _____
   b. If there have been any parental separation or divorce, please give date(s), name(s) of the parental figures and list which parent(s) has legal custody and primary residential placement:
_____
_____

4. How does your child usually react to problems or difficulties? _____
_____

5. What kind of discipline works best? _____
_____

6. Has your child ever been physically or sexually abused? _____
_____

7. How does your child get along with other children his/her own age? _____
_____

8. What are your child's positive qualities and personal strengths? _____
_____

9. What are your child's special interests or talents? _____
_____

10. What helps your child to feel safe? _____
_____

11. Has your child ever had a head injury, seizures, convulsions or loss of consciousness?
If yes, state age: _____
_____

12. Are there any other medical problems your child has, including allergies? _____
_____

13. List any medications your child takes, including vitamins and nonprescriptive drugs: _____
_____

14. Family history of difficulties: Check all that apply and list the relationship of family members to the child, include Parents, Siblings, Grandparents, Aunts, Uncles and Cousins:

_____ Mental Illness _____
_____ Emotional Problems _____
_____ Alcoholism/Drug Abuse _____
_____ Behavioral Problems _____
_____ Learning Disability _____
_____ Retardation _____
_____ Legal Problems _____
_____ Seizures/Epilepsy/Neurological Problems _____

DEVELOPMENTAL HISTORY

Pregnancy and Birth

1. Was the pregnancy planned? _____ Yes _____ No

2. What was the family situation during the pregnancy? _____ Happy _____ Unhappy
   Explain: _____
   _____

3. What was the mother's condition during pregnancy? Check all that apply:
   _____ Fevers _____ Under 17 during pregnancy _____ Diabetes
   _____ Used drugs _____ Over 35 during pregnancy _____ Toxemia
   _____ Drank alcohol _____ Smoked _____ Injuries
   _____ Other problems _____
   List any medications taken during pregnancy: _____
   _____

4. Labor and delivery problems? Check all that apply:
   _____ Caesarian section _____ Labor less than 2 hours _____ Cord around baby's neck
   _____ Breech _____ Labor more than 24 hours _____ Mother asleep at delivery
   _____ Forceps used _____ Labor induced _____ Other problems
   _____
   _____

5. Birth weight: _____ lbs. _____ oz.
   Condition at Birth: _____ OK Problems? Check all that apply:
   _____ Jaundice _____ Infection _____ Premature _____ Anemic
   _____ Trouble breathing _____ Needed oxygen _____ Trouble sucking
   _____ Birth defects _____ Needed surgery _____ in ICU
   _____ Hospitalized for more than 5 days _____ Other problems
   _____
   _____

Infancy (0 - 12 months)

1. List any major family events during this time period (for example, deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc.). Include baby's age and general reaction: _____
   _____

2. List any major illnesses, injuries or hospitalizations: _____
   _____

3. Describe any feeding/eating difficulties: _____
   _____

4. Describe any sleeping difficulties: _____
_____

5. What was your baby like? Check all that apply:

_____ Cuddly	_____ Difficult to soothe	_____ Social
_____ Fussy	_____ Slow to adjust to change	_____ Quiet

Toddler Years (12 months to 3 years)

1. List any major family events during this time period (for example, deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc.). Include child's age and general reaction: _____
_____

2. List any major illnesses, injuries or hospitalizations: _____
_____

3. List any unusual habits, mannerisms or fears: _____
_____

4. a. How old was your child when he/she spoke his/her first words? _____
   b. How old was your child when he/she used complete sentences? _____

5. At what age did your child first walk? _____

6. a. How old was your child when he/she started toilet training? _____
   b. How old was your child when he/she completed toilet training? _____
   c. List any difficulties: _____
   _____

7. Did your child have any problems with separation from his/her parents? _____
_____

8. List any behavioral problems with your child: _____
_____

Preschool (ages 3 - 6) (omit if child is under 3)

1. List any major family events during this time period (for example, deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc.). Include child's age and general reaction: _____
_____

2. List any major illnesses, injuries or hospitalizations: _____
_____

3. List any unusual habits, mannerisms or worries: _____
_____

4. Describe how your child gets along with other children: _____
   _____

5. List any behavioral problems with your child: _____
   _____

6. Is your child fearful of new people and/or new situations? If yes, explain: _____
   _____

7. Do you have any special concerns about your child during this age range? Check all that apply and explain below:
   _____ Eating problems _____ Sleeping problems _____ Speech problems
   _____ Toileting problems _____ Bed wetting _____ Temper tantrums
   _____ Other problems _____
   _____

8. List any daycare and/or babysitting problems: _____
   _____

9. Did your preschooler exhibit any unusual behavior? Check all that apply:
   _____ Quiet _____ Over active _____ Easily frustrated
   _____ Clumsy _____ Usually happy _____ Demanding
   _____ Often sad or angry _____ Often fell _____ Difficulty separating

Middle Childhood Period (ages 6 - 11) (omit if child under 6)

1. List any major family events during this time period (for example, deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc.). Include child's age and general reaction: _____
   _____

2. List any major illnesses, injuries or hospitalizations: _____
   _____

3. List any unusual habits, mannerisms or worries: _____
   _____

4. List names of your child's school(s) and the grades he/she has attended: _____
   _____

5. How was your child's adjustment to changing schools? _____
   _____

6. Did you have any problems getting your child to go to school? If yes, explain: _____
   _____

7. Describe your child's relationship with his/her teachers: _____
   _____

8. Describe your child's relationship with other children: _____
_____

9. Does your child have a "best" friend? _____
_____

10. List any problems your child has with attitude towards school or their grades: _____
_____

11. Did your child repeat any grade? If yes, which grade(s): _____
_____

12. Did your child attend any special classes? If yes, during which grade and for what reason:
_____
_____

13. Are you or your child's teachers concerned about any of the following? Check all that apply:
_____ Speech _____ Reading _____ Writing
_____ Hearing _____ Vision _____ Behavioral
_____ Eye-hand coordination
If yes, explain: _____
_____

14. Does your child have any problems or worries about sex? _____
_____

15. Does your child have any signs of puberty?
_____ Menstruation _____ Growth spurt _____ Voice change
What is your child's reaction to this? _____
_____

Adolescence (ages 12 - 19) (omit if child is under 12)

1. List any major family events during this time period (for example, deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc.). Include child's age and general reaction: _____
_____

2. List any major illnesses, injuries or hospitalizations: _____
_____

3. List any unusual habits, mannerisms or worries: _____
_____

4. Does your child have any eating problems or problems with weight gain or loss? _____
_____

5. Does your child have any problems sleeping? _____
_____

6. Does your child have any academic problems at school? _____
_____

7. Does your child have any behavioral problems? _____
_____

8. At what age did your child experience the following:
_____ Growth spurt _____ Voice change _____ Menstruation

9. Are there any special concerns or reactions to these physical changes? _____
_____

10. Do you have any concerns about your child's friends? _____
_____

11. Have there been worries or concerns about sex or sexual activity? _____
_____

12. Does your child smoke, use alcohol or take drugs? If yes, explain: _____
_____

13. Has your child had any trouble with the law/police? If yes, explain: _____
_____

14. Has your child held a job(s)? If yes, list and note any concerns: _____
_____

15. Have there been problems about rules, curfew, where your child goes, etc? _____
_____

16. Has your child gotten into any physical struggles with an adult(s)? If yes, explain:
_____
_____

17. What specific changes would you want to see happen to feel that your therapy experience has been successful? _____
_____

18. Is there anything else that would be helpful to know about your child or family?
_____
_____

Thank you for your attention to this detailed survey.