ATLANTA AREA PSYCHOLOGICAL ASSOCIATES, P.C.

DEVELOPMENTAL HISTORY

Child's Name: _____ Birth Date:_____ Age:_____ **M F**

Child's School: _____

*** Name of School *** *** School Address *** *** County *** *** Grade ***

Parent 1: _____ bio adoptive foster grand How much of week? _____

Parent 2: _____ bio adoptive foster grand How much of week? _____

Parent1 Home Phone: _____ Cell Phone: _____ email: _____

Parent1 Address: _____

Parent 2 Home Phone: _____ Cell Phone: _____ email: _____

Parent2 Address: _____

Is there another person who cares for the child?_____

Is there a parent who is not involved in the child's life? _____

_____

Is there a custody agreement or order? What does it say? (Also, ***please provide us with a copy***.)

_____

_____

Has your child changed residences in the past 12 months? **Y N** Please explain: _____

_____

_____

Goals (what you want to accomplish): How will you know if we have helped your child?

_____

_____

_____

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Mother's Health During Pregnancy (Please check) √

	Excessive Vomiting		Infection		Threatened Miscarriage
	Toxemia		Surgery		Other Illness:
	Alcohol /Drug Use? How much?		Smoking? # cigs/day:	Meds Taken: _____	

Delivery (Please check) √

	Spontaneous Labor (or)		***Infant Presented:***		***Complications:***
	Induced Labor		Vertex (normal)?		Cord Around Neck?
Hours in Labor:			Breech (feet first)?		Cord Presented First?
Forceps? **Y N**			Caesarean Delivery		Hemorrhage/Bleeding?

# Weeks Gestation:	**Weight at Birth:**	**Days in Hospital:**
	Injured During Delivery?	
	Other issues:	

Post-Delivery Period (Please check) √

	Respiration Delayed – How Long?:				Mucus Accumulation
	Crying Delayed – How Long?:				Jaundice
	Cyanosis (blue)?		Sucking - Strong		Incubator – # of days?
	Infection		Sucking – Weak		Apgar Score:
	Vomiting		Diarrhea?		Rh Factor? **Y N**
Other Issues: _____					

Infancy – Toddler Period (Please check) √

	Did not enjoy cuddling		Excessively Restless		Poor sleep, waking often
	Not calmed by holding		"Into everything"		Frequent Headbanging
	Colicky/Stomach Problems		Feeding Problems		Excessive Accidents
Please Explain: _____					

Motor Skills – Rate Your Child: **G**=Good **A**=Average **P**=Poor **CD**=Cannot Do

	Walking		Running		Writing
	Catching		Throwing		Shoelace Tying
	Buttoning		Jumping		Athletic Ability
	Using Scissors		Accident-prone?		

Child showed this Ability	[Typical Age]	At What Age?	Comments
Smiles	2-4 months		
Sits w/o Support	6-8 months		
Responds to Own Name	6-8 months		
Crawls	5-9 months		
Stands w/o Support	12-15 months		
Walks w/o Support	10-16 months		
Uses cup, spoon w/o help	16-24 months		
Follows verbal instructions	24 months		
1st Words (Not Mama/Dada)	18 months		
Says Phrases (2-4 words)	2 years		
Spoken Sentences	3 years		
Bladder Trained - Day	3 years		
Rides Tricycle	3 years		
Bowel Trained - Day	36-42 months		
Bowel Trained - Night	36-42 months		
Buttons Clothes	4-5 years		
Says Alphabet	4-5 years		
Names Coins	5-6 years		
Begins to Print	5-6 years		
Begins to Read	5-7 years		
Ties Shoelaces	6 years		
Bladder Trained - Night	6 years		
Bike w/o training wheels	6 years		

School Performance

To the best of your knowledge, at what grade level is your child functioning?			
Spelling:	Writing:	Reading:	Math:
Has your child ever repeated a grade? Y N Which Grade?			

√	**My child has or had:**				
	Special Pre-K		Early Intervention (EIP)		Small Class Size
	Extra Teacher in Class		Behavior Aide in Class		In-School Tutoring
	Behavior Plan/Contract		Social Skills Group		Speech Therapy
	Special Education		Student Support Team-SST		Occupational Therapy

Other Special Help your child has received: _____

Special Education Eligibility Category: _____
(Other Health Impaired, Specific Learning Disability, etc.)

Please rate your child's experiences in each grade:

	Academics	**Behavior**
Pre-K		
1st Grade		
2nd Grade		
3rd Grade		
4th Grade		
5th Grade		
6th Grade		
7th Grade		
8th Grade		

Results of Standardized Testing (Milestones, ITBS, PSAT, etc):

_____

_____

Has your child attended Private, Special Schools, Home School or Tutoring? **Y N** Please explain:

_____

_____

High School Experience

	Academics	**Behavior**
9th Grade	_____	_____
10th Grade	_____	_____
11th Grade	_____	_____
12th Grade	_____	_____

Current Classroom Behavior Problems: (Please check) √

	Doesn't sit still in his or her seat		Shouts out, doesn't wait to be called upon
	Frequently gets up, walks around the classroom		Doesn't pay attention in group activities
	Typically does better in one-on-one relationship		Doesn't cooperate well in group activities
	Does not finish class work in allotted time		Frequent conflicts with other students
	Small issues blow up into major problems		Bullying/Picks on other students
	Behavior problems on school bus		Bullied/Picked on or Teased by others
	Poor organization/Messy desk and/or locker		Forgets to turn in completed work
	Argues with teacher/Resists authority		Stealing
	Skips classes		Truant/Skips school
	Lies about homework		
Other School Behavior Problems:			

Current Home Behavior Problems

Most children exhibit, to some degree, the kinds of behavior listed below. Check those that your child exhibits ***to an excessive or exaggerated degree***, when compared to other children his or her age.			
√	**(Please check)**	√	**(Please check)**
	Hyperactivity or Restlessness		Complains of boredom
	Impulsive behavior		Low tolerance for frustration
	Sloppy table manners		Interrupts frequently
	Punishment does not affect behavior		Temper outbursts
	Conflicts with other children in family		Messy, resists cleaning up
	Conflicts with other children in neighborhood		Heedless to danger/Excessive risk taking
	Conflicts with one or both parents		Overly concerned with fairness/evenness
	Does not listen when spoken to		Resists going to school
	Isolates in his/her room		Leaves without permission
	Slow moving/Late getting ready in AM		Does not respect curfew/Late returning
Other Home Behavior Problems:			

Phone/Computer/Electronics:

Does your child have a phone? **Y N** Access to the Internet? **Y N** Facebook/Instagram etc.? **Y N**
Does your child play video or computer games in much or most of his/her free time? **Y N**
Do you actively manage your child's media use (TV, movies, games) by ratings? **Y N**
Does your child spend excessive time texting, or on their phone or Internet? **Y N**
Do you have Parental Controls on your child's devices? **Y N Some**
Do you actively monitor your child's activities on their devices? **Y N Don't Know How**
Does your child become overly upset when you limit his/her access to electronics? **Y N**
Have you ever been concerned about your child's use of, or activities on, their electronics? **Y N**
Other concerns about electronics:_____

Peer Relationships: **(Please check)** √

	Seeks friendships with peers		Shy, difficulty making friends
	Other children like him/her, want to be friends		Bossy, has to have things his/her way
	Difficulty "reading" others' feelings		Prefers **younger** / **older** friends (circle)
	Overly friendly with strangers		Difficulty keeping friends
Other problems with peers:			

Interests and Accomplishments

Sports:	√		Arts:	√		Other:	√	
		Baseball			Musical Instrument			Board Games
		Football			Singing			Building things
		Soccer			Visual Arts			Dolls
		Basketball			Theater			Action Figures
		Lacrosse			Drawing/Coloring			Television/Computer
		Track and Field			Reading			Seeing friends
		Martial Arts			Creative Writing			Bike/Skateboard
		Tennis			Swimming			Video Games
Other Activities:								
What does your child most ***dislike*** doing?								

Child's Pediatrician: _____ Name of Group: _____

Pediatrician Phone: _____ Pediatrician Fax: _____

Other Medical Providers Who Serve My Child:

Name	**Practice Name**	**Phone**	**Fax**	**Last Visit**

Child's Medical History - please check √

Head Injury **Y N**			Meningitis		Chicken Pox
	Lost Consciousness		Encephalitis		Measles
	Did not Lose Consciousness		Reaction to Vaccine		Mumps
Convulsions/Seizures			Highest Fever Ever: °		Whooping Cough
	w/Fever: °		Poisoning:		Mono-neucleosis
	Without Fever		Coma: days		Pneumonia
Please explain above:_____					

Current or Past Medical Issues

	Eye Problems:
	Ear Problems:
	Surgeries:
	Complications:
	Hospital Stays:

Child's Present Medical Status

Height:		Illnesses treated for: _____	
Weight:			
Medications:	Name:	What For?	
	Name:	What For?	
	Name:	What For?	

Family History - Mother

Age:	Age when pregnant with patient:	Number of previous pregnancies:	
Problems conceiving:		Miscarriages:	Terminations:
Highest Grade Completed:		Grade Repeated?	
Behavior Problems:			
Medical Problems:			
Do any relatives have mental health or learning problems?_____			

Family History – Father:

Age:	Father's age when mother was pregnant with patient:	
	Highest Grade Completed:	Grade Repeated?
Behavior Problems:		
Medical Problems:		
Do any relatives have mental health or learning problems?_____		

Child's Siblings (Brothers and Sisters)

Name	Age	Natural, Half Or Step?	Medical, Social, Emotional or Academic Problems?

Names and Addresses of Other Professionals Consulted:

Name	Type of Provider	Reason Seen	When, and How Many Times?

Feeding Issues

√	Please check **and explain**		
	Picky Eater:		
	Overeating:		
	Sweets:		
	Snacking:		
	Food Allergy:		
Time of Meals-	Breakfast:	Lunch:	Dinner:
Issues with Food?			

Sleeping

Own Room? **Y N**	If no, shared with:	
Usual Bedtime:	Usual Wake-up:	Hours slept:
Sleep Problems: _____		

Personality Traits

√	**Please check and explain**
	Shy:
	Demanding:
	Fearful:
	Aggressive:
	Jealous:
	Argues:
	Talks back:
	Teases/Bullies:
	Gets Teased/Bullied:
	Sensitive/Easily Hurt:
	Anger Towards Self:
	Obsessive/Stuck on Thoughts:
Child's **best** qualities:	
Child's **most difficult** qualities:	

Supervision

Is the child cared for by others? _____
Does any parent travel a lot? _____
Do parents differ about discipline?_____
Does any parent have more difficulty than others? _____
In which situations is your child more difficult? _____
Discipline methods used: _____

My child needs help in doing these things: (please circle)

Dressing Undressing Washing Toileting Eating

Please explain: _____

Is there anything else you would like us to know about your child? _____

_____

_____

_____

_____

_____