DEVELOPMENTAL HISTORY (Rev 1/08)

Child's Name _________________________________Age _____ Birthdate _________________

Address ____

Phone Numbers: Home_______________ Work _______________ Cell ____________________

Mother's Name __________________ Age ____ Education & Occupation _________________

Father's Name ___________________ Age ____ Education & Occupation _________________

Sibling Names _______________________ Age ____

_________________________ Age ____

CHILD DEVELOPMENTAL HISTORY

Birth weight_______ Premature? ____ Full term? ____ Overdue? _____

Type of delivery: Vaginal? ____ Cesarean? ____

Any problems with pregnancy or delivery? Describe:____________________________________

____

Condition of child at birth: ____

____

Child was: breast fed? ____ Bottle fed? ____

Any feeding difficulties? ____

Toilet Training: bladder training completed at: ____

Bowel training completed at ____

Any comments? ____

27620 Farmington Rd., Suite 207 ● Farmington Hills, MI ● 48334 ● 248.324.9094

Describe any special problems during infancy: ____

____

Age at which child crept ____   walked ____

Age at which child said first word _____   spoke in sentences _____

Any speech problems?____

Any bedtime or sleeping problems? ____

MEDICAL

Name of Physician: ____________________________   Phone: __________________________

Dates of: last physical exam: ___________   hearing exam __________   eye exam _________

Has your child ever had: __ eye/visual problems   __ ear/hearing problems

__ high fever   __ head injury

__seizures/convulsions

Describe those checked above: ____

Any severe diseases or injuries ____

List any medications being taken ____

Date(s) and reasons for any hospitalizations ____

Does or has your child shown any of the following: (please check all that apply)

__ bedwetting   __stealing

__ sleep walking   __ lying

__ bad dreams   __ fear of school

__ eating problems   __ persistent fears or worries

__nausea or vomiting   __anger outbursts

__shyness   __nail biting

__ hair pulling   __reading problems

__overactive behavior __truancy from school

__cigarette, alcohol or drug use

SCHOOL/DAYCARE

What are your child's interest or hobbies: ____

List (in order) daycare centers and schools your child has attended to the present time:

____

____

Current grade: ____ Teacher: _________________________

Has your child participated in any special education programming? __ yes __ no

If yes, please describe: ____

____

Comments: ____

____