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Child Developmental History Record

A. Identification

1. Child's name: _____ Birthdate: _____Age: _____
Person(s) completing this form: _____ Today's date: _____

2. Mother's name: _____ Birthdate: _____Home phone: _____
Full Address: _____
_____
Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

3. Father's name: _____ Birthdate: _____Home phone: _____
Full Address: _____
_____
Currently employed: ❑No ❑Yes, as: _____ Work phone: _____

4. Parents are currently:

❑Married ❑Divorced ❑Remarried ❑Never Married ❑ Other: _____

Child's custodian/guardian is: _____

5. Stepparent's name: _____ Birthdate: _____ Home phone:_____
Address: _____
_____
Currently employed: ❑No ❑Yes, as: _____ Work phone: _____

6. Other adult family members?

_____

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B. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery Prenatal medical illnesses and health care:

_____

_____

_____

_____ Was the child premature? ❑No ❑Yes

Weight and height at birth: _____ pounds _____ inches

Any birth complications or problems?

_____

_____

_____

2. The first few months of life

Breast-fed? If so, for how long? Any allergies? Food allergies?

_____

_____

_____

_____

Sleep patterns or problems:

_____

_____

_____

_____

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Personality:

_____

_____

_____

_____

3. Milestones:

At what age did this child do each of these?

Sat without support: _____ Crawled: _____ Walked without holding on: _____
Helped when being dressed: _____ Tied shoelaces: _____ Buttoned buttons: _____
Ate with a fork: _____ Stayed dry all day: _____
Didn't soil his or her pants: _____ Stayed dry all night: _____

4. Speech/language development

Age when child said first word understandable to a stranger: _____
Age when child said first sentence understandable to a stranger: _____
Any speech, hearing, or language difficulties?

_____

_____

C. Eating

Is child a picky eater? _____ Eat a variety of foods? _____

What is a typical day of eating breakfast/lunch/snacks/dinner_____

_____

Complaints of stomach aches after eating? _____

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Are there food allergies? _____

Has there been any testing for food sensitivities? _____

Are there any unexplained rashes or other skin conditions? _____

_____

Has there been a diagnosis of Celiac or Non-Celiac Gluten Sensitivity? _____

D. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

E. Residences

1. Homes

Dates From To	Location	With whom	Reason for moving	Any problems?

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2. Residential placements, institutional placements, or foster care

Dates From to	Program name or location	Reason for placement	Problems?

F. Schools

School (name, district, address, phone)	Grade	Age	Teacher

May I call and discuss your child with the current teacher or school social worker ? ❑Yes ❑No

Name and # _____

G. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.:

_____

_____

_____

H. What are the biggest stressors for the child

_____

_____

_____

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I. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important? How much electronic time daily?

_____

_____

_____