Kym Lundberg, MFT Associate
Intern # IMF95251
Supervised by Rebekah Balboni, LMSW
License # 24270

Child Developmental History Record

A. Identifications

Child's name: _____ Birthdate: _____Age: _____

Person(s) completing this form: _____ Today's date: _____

Mother's name: _____ Birthdate: _____Phone: _____

Address: _____

Father's name: _____ Birthdate: _____ Phone: _____

Address: _____

Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other: _____

Child's custodian/guardian is: _____

Stepparent's name: _____

Address:_____

Stepparent's name: _____

Address:_____

Other adults in the home? Other family members?

_____

_____

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--

Sleep patterns or problems:

_____

_____

Personality:

_____

_____

3. Milestones: At what age did this child do each of these?

Crawled: _____ Walked: _____

Could dress self: _____ Ate with a fork: _____

Stayed dry all day: _____ Stayed dry all night: _____

4. Speech/language development

Age when child started speaking: _____

Any speech, hearing, or language difficulties?

_____

_____

5. School-age years

How did child adjust to attending school?

_____

_____

Please describe child's personality and behavior during elementary years

_____

_____

Middle school years (if applicable)

_____

_____

High school years (if applicable)

_____

_____

C. Health

List all childhood illnesses, hospitalizations, 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?

D. Medication

Please list current medications, including dosage, if applicable

_____

_____

E. Residences

Dates From	To	Location	With whom	Reason for moving	Problems?

F. Schools

School (name, district, phone)	Grade	Age	Teacher

_____

_____

Has your child ever been evaluated to determine if there is a Learning Disability ❑ Yes ❑ No
Does your child receive Special Education services? ❑ Yes ❑ No
Is there a current IEP? ❑ Yes ❑ No

G. Current Symptoms:

When did child's symptoms first appear? How did it impact child and his/her family?

_____

_____

Special skills or talents of child: List hobbies, sports; recreational, musical, TV, and toy preferences; etc.:

_____

_____

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

_____

_____