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Developmental History - Child

Patient Name:				
	First	Middle	Last	
Date of Birth:				
Today's Date:	oday's Date: Person Completing this Form:			
Please describe yo	our main concerns	s:		
Family Inforn	uation_			
Parents are: Not married and			□Not married but live together	
Please list any step	p-parents or other	r adults involved signific	antly in caretaking:	
Please list siblings	and ages:			
•	•	-	ety, ADHD or other mental health	
\mathcal{E}		, <u> </u>		
Please describe an	y significant stre	ssors that may be affecting	ng your child:	
Social Develop	ment			
Briefly describe y	our child's person	nality:		
Please list any ext	racurricular activ	ities:		

☐Yes ☐No If yes, with whom?

Does your child have a history of concussion? □Yes □No
If yes, when and how long before symptoms resolved?
Please list any medications your child is currently taking:
Do you have any concerns that your child may be using cigarettes, other nicotine products, alcohol, or illegal drugs? □Yes □No
If yes, please explain:
Academic History
Current School: Grade Level:
Other schools attended, beginning with preschool:
Has your child ever skipped a grade? □Yes □No Been retained? □Yes □No
Has your child ever received tutoring services or been evaluated/testing for learning problems?
If yes, please describe:
Is your child currently having academic difficulty? □Yes □No
If yes, please describe:
Is your child experiencing behavioral problems in school? □Yes □No
Has your child ever been suspended? □Yes □No Or been expelled? □Yes □No
If yes to any of the above, please describe:
Does your child have a 504 Plan, an IEP or a formal written learning plan on file at school?
Please describe the services your child receives:
Is there any other information not covered on this form that you feel would be helpful or relevant?