NAPERVILLE
CLINICAL ASSOCIATES

CHILDHOOD DEVELOPMENTAL HISTORY

Person Completing Form _____ Relationship to Child _____ Date _____

Child's Name _____ Birthdate _____ Age _____

Home Address _____
(Street) (City/Town) (State) (Zip code)

Telephone _____ (cell) _____ (home)

Adults living with Child (Name and relation) _____

Siblings (name and age) _____

PARENTS

Father _____ Occupation _____ Telephone _____

Mother _____ Occupation _____ Telephone _____

Pregnancy Complications (Please describe)

_____

_____

INFANCY:

Difficult to calm or comfort _____ Colicky _____ Excessively irritable _____ Head Banging _____

Difficulty nursing _____ Disturbed sleep patterns (describe) _____

Other: _____

MEDICAL HISTORY:

Childhood Diseases (describe ages and complications) _____

Hospitalizations _____

Head Injury _____ Eye problems (specify) _____

Ear problems (specify) Allergies (specify) _____ Asthma _____

Eating Problems _____

Sleep Disorders _____

Other Problems _____

_____ Date _____
Signature of Patient or Legal Guardian

MENTAL HEALTH HISTORY

Describe any past history of severe social, emotional or behavioral problems

_____

Describe any significant history of physical or emotional trauma

_____

List previously seen mental health providers and addresses if available

_____

PRESENT MEDICAL STATUS

Present illnesses for which the child is being treated _____

Prescription Medication(s) _____

Name of Primary Care or other treating physicians _____

DEVELOPMENTAL MILESTONES

Where all developmental milestones reached within normal range?

Yes _____

No _____ Please describe _____

SCHOOL EXPERIENCE

Child's School _____

Grade _____ Special School Placement or Services (if any) _____

Has your child ever been evaluated for a 504 Plan or Special Education? _____ If so, for what

reason _____

BEHAVIOR CHECKLIST

Please check all of the following that apply to your child:

☐ Is moody	☐ Has a bad temper	☐ Cries easily
☐ Is a worrier	☐ Has bad dreams	☐ Is often sad
☐ Is often quiet	☐ Is fearful of new situations	☐ Is fearful of being alone
☐ Is often tired	☐ Stutters or stammers	☐ Frequent stomach aches
☐ Frequent headaches	☐ Wets bed or pants often	☐ Soils or has bowel accidents
☐ Frequent diarrhea	☐ Frequent constipation	☐ Overeats
☐ Bites nails	☐ Is slow to trust	☐ Demands to be the center of attention
☐ Fights with siblings	☐ Excessively neat or orderly	☐ Too concerned with germs/cleanliness
☐ Tells lies	☐ Steals	☐ Plays with fire
☐ Bullies other children	☐ Is fresh or rude to adults	☐ Is mean
☐ Destroys own property	☐ Destroys others property	☐ Deliberately provokes adults
☐ Frequently in trouble with neighbors	☐ Is cruel to animals	☐ Is a loner
☐ Has no real friends	☐ Has mostly younger friends	☐ Has mostly older friends
☐ Is bossed by other children	☐ Prefers to play alone	☐ Gets picked on
☐ Is not liked by other children	☐ Difficulty sustaining attention	☐ Makes careless mistakes
☐ Often does not seem to listen	☐ Fails to finish things	☐ Difficulty organizing activities
☐ Avoids sustained mental effort	☐ Often loses things	☐ Easily distracted
☐ Forgetful in daily activities	☐ Often fidgets	☐ Often out of seat in the classroom
☐ Is hyperactive	☐ Difficulty playing quietly	☐ Talks excessively
☐ Blurts out answers	☐ Difficulty waiting turn	☐ Often interrupts or intrudes
IF YOUR CHILD IS 12 YEARS OR OLDER		
☐ Is sexually active	☐ Appears confused about gender	☐ Displays interest in the same sex
☐ Behavior is rigid and repetitive	☐ Is troubled by obsessive thoughts	☐ Has many health complaints
☐ Experiences times of extreme fear or panic	☐ Uses alcohol	☐ Uses illegal drugs
☐ Inhales household chemicals		