SIOUX FALLS PSYCHOLOGICAL SERVICES | "A House on the Rock" STRONGHOLD COUNSELING SERVICES, INC. | river COUNSELING SERVICES

Child and Adolescent Developmental History

(Please fill out this form completely and bring it to your first session) Date _____

General Information

Your Name _____ Relationship to Child: _____
First MI Last

Child's Name _____ Birth Date _____ Age_____
First MI Last

Child's Current Address_____ City_____ State_____ Zip_____

Child's Prior Places of Residence

_____ _____ _____
_____ _____ _____
_____ _____ _____

School or Daycare _____ Grade _____

How often does this child attend school/daycare? _____

Family Information

1) Do you feel that your family has adequate social, mental/emotional, or financial support? _____ Yes _____ No

2) Does your family identify itself with a particular cultural or ethnic group? _____ Yes _____ No

If yes, describe the influence or role this plays in your family. _____

_____

_____

3) Does your family identify itself with a particular religious or spiritual group? _____ Yes _____ No

If yes, describe the influence or role this plays in your family. _____

_____

_____

4) Does your family have other significant sources of emotional, mental, or financial support? _____ Yes _____ No

If yes, please list and describe how you are supported and the impact of this support on your family _____

_____

_____

5) Please list any and all individuals who **live** with the child:

Include name, age, and relationship to child

_____ _____ _____

_____ _____ _____

_____ _____ _____

6) Are the child's parents separated and/or divorced? ☐ Yes ☐ No

If yes, what month and year did the parents separate? _____

Who has legal custody? _____ Who has physical custody? _____

7) What is the name and address of the other biological parent? _____
First *MI* *Last*

Address_____ City _____ State_____ Zip_____

8) Does the other parent know of this evaluation? ☐ Yes ☐ No

If no, why? _____

9) Describe the other parent's contact with the child. Check all that apply.

☐ Regular and frequent contact
☐ Irregular and unpredictable contact
☐ No contact with child
☐ Regular but limited contact
☐ No knowledge of child

10) Parent/Caregiver Occupation(s) _____

11) If the child does not live with biological/adoptive parent(s), provide the following information. Are you:

☐ Foster parent(s)
☐ Adoptive parent(s)
☐ Legal guardian(s), biologically related to the child - Relation: _____
☐ Legal guardian(s), not biologically related to the child

12) If applicable, please state why the child is in foster care or with a guardian:

_____

_____

Foster Parent/Guardian Name(s) _____ Phone _____

Foster/Guardian Address _____ City _____ State_____ Zip_____

Caseworker Name(s) and Phone Number(s):

_____

_____

13) Is the child adopted? _____ Yes _____ No *Skip to question 14 if child is not adopted.*

If yes, is there contact with the biological family? _____ Yes _____ No

At what age was the child adopted? _____ From where was the child adopted? _____

Are there concerns about the adoption? _____ Yes _____ No

If yes, briefly explain? _____

Family Relationships

14) Describe the child's relationship with you and/or other primary caregiver(s):

_____

_____

15) Describe how the child is disciplined and who disciplines them?

_____

_____

Are all caregivers in agreement with how the child is disciplined? _____ Yes _____ No

If no, briefly explain _____

How does the child respond to discipline? _____

16) Please list any of the child's biological family members who have a history of mental illness or disorders:

Include name, age, and relationship to child

_____ _____ _____

_____ _____ _____

17) Please list any of the child's biological family members with a history of problematic substance use and/or addiction:

Include name, age, and relationship to child

_____ _____ _____

_____ _____ _____

18) Please list any significant life events the child has experienced. These are events that were negatively significant in the eyes of the child or in which the child's response was not average, expected, or compared to their peers.

_____

_____

Does the child's parent/caregivers(s) have a history of trauma during their lifetime? _____ Yes _____ No

If yes, please explain? _____

Medical History

19) List the following information for any or all of the child's health care providers who have either provided significant health care in the past or are currently providing regular care:

Name/Provider _____ Organization _____

Location _____

Treated for _____ _____ Past _____ Current

Name/Provider _____ Organization _____

Location _____

Treated for _____ _____ Past _____ Current

Name/Provider _____ Organization _____

Location _____

Treated for _____ _____ Past _____ Current

Name/Provider _____ Organization _____

Location _____

Treated for _____ _____ Past _____ Current

20) Date of most recent physical exam _____ Were results normal? _____ Yes _____ No

If no, explain _____

21) Does the child participate in regular immunizations and/or vaccinations? _____ Yes _____ No _____ Unsure

Explain _____

22) Are you willing to sign a release so the therapist can communicate with the child's physician? _____ Yes _____ No

23) Has this child received previous counseling or psychiatric care? _____ Yes _____ No

Explain _____

24) Is the child currently taking any prescription or over-the-counter medications? _____ Yes _____ No

Medication	*Dosage*	*Reason for Medication*
_____	_____	_____
_____	_____	_____
_____	_____	_____

25) Has anyone ever prescribed medication for the child that you decided not to administer? _____ Yes _____ No

If yes, explain _____

_____

26) Has the child been hospitalized for medical treatment? _____ Yes _____ No

Reason for Treatment *Date*

_____ _____

_____ _____

_____ _____

27) Please check any of the following medical or physical conditions this child currently has or has had in the past?

_____ Headache	_____ Dizziness	_____ Trouble with hearing	_____ Bed wetting
_____ Frequently ill	_____ Nausea	_____ Stomachache	_____ Chronic constipation
_____ Frequent ear infections	_____ Vomiting	_____ Aches or pains	_____ Language delays
_____ Soiling	_____ Weakness	_____ Head injury	_____ Speech problems
_____ Daytime toilet accidents	_____ _____	_____ _____	_____ _____

Explain _____

28) Does the child have any allergies? _____ Yes _____ No

If yes, list _____

29) Does the child have any sensitivities or difficulties with the following? Check all that apply.

_____ Tactile (touch)	_____ Auditory (sound)	_____ Taste and smell	_____ Coordination
_____ Vestibular (movement)	_____ Visual	_____ Muscle tone	

Explain _____

30) Describe the child's sleeping patterns. Please include any past or present concerns or difficulties.

_____

_____

Social/Emotional Health

31) In your own words, state the reason or behavior for which you are seeking therapy.

_____

_____

32) What are your goals and/or expectations for therapy?

_____

33) How would you describe the child? Check all that apply.

☐ Affectionate	☐ Disturbing thoughts	☐ Impulsive	☐ Poor self-esteem
☐ Always in motion	☐ Eating too little	☐ Inappropriate sexual behavior	☐ Prefers playing/being alone
☐ Appears to daydream/space out	☐ Eating too much	☐ "In their own little world"	☐ Respects authority
☐ Anxious/frequent worrying	☐ Eats inedible things	☐ Irritable mood	☐ Runs away from home
☐ Bored often/easily	☐ Excessively fidgets	☐ Lies	☐ Sadness/depression
☐ Bossy/demanding	☐ Fascination with fire	☐ Mean/rude to others	☐ Self-abusive behavior
☐ Bullied by others	☐ Fear making mistakes	☐ Mood changes quickly	☐ Shows poor judgement of danger
☐ Cooperative	☐ Follows directions well	☐ More active than other children	☐ Shy
☐ Cruelty to animals	☐ Frequent physical accidents	☐ Nail biting	☐ Skips classes or school
☐ Destructive/aggressive	☐ Frequent physical complaints	☐ Nightmares	☐ Steals
☐ Difficulty paying attention	☐ Gets distracted watching TV, etc.	☐ Obsessive thoughts	☐ Stubborn
☐ Difficulty with transitions/change	☐ Gets easily frustrated	☐ Odd behavior	☐ Temper tantrums
☐ Difficulty with separation	☐ Head banging	☐ Often tearful	☐ Thumb sucking
☐ Difficulty completing tasks	☐ High emotional sensitivity	☐ Poor eye contact	☐ Well behaved
☐ Disorganized	☐ Immature	☐ Poor listening	☐ Willing to try new activities

34) Describe the child's friends. How does the child relate to other children?

_____

_____

35) How does the child function in group settings?

_____

_____

36) What are the child's strengths?

_____

_____

37) Has the child ever talked seriously about hurting or killing someone/something, or done so? _____ Yes _____ No

If yes, when and what were the circumstances? _____

_____

Perinatal/Prenatal History

38) Please explain the relationship between the child's father and mother during pregnancy.

_____

39) Was the pregnancy planned? ☐ Yes ☐ No

40) Did the child's parents experience fertility issues or difficulty conceiving? ☐ Yes ☐ No

If yes, explain _____

41) How many pregnancies did the child's mother have prior to this child? _____

42) Were there any miscarriages prior to this child? ☐ Yes ☐ No *If yes, how many?* _____

43) Did the mother receive consistent prenatal care? ☐ Yes ☐ No *If no, why?* _____

44) To your knowledge, did the child's father regularly consume any substances (nicotine, medication, alcohol, marijuana and/or other recreational drugs) during the conception of the child? _____ Yes _____ No

If yes, what? _____

45) To your knowledge, did the child's mother regularly consume any substances (nicotine, medication, alcohol, marijuana and/or other recreational drugs) while pregnant with the child? _____ Yes _____ No

If yes, what and how often? _____

46) Did the mother experience any of the following during pregnancy? Check all that apply.

_____ Illness
_____ Significant stressors
_____ Diabetes
_____ Accidents/injuries
_____ Domestic violence
_____ Mental health concerns
_____ _____
_____ _____

47) Did any other significant trauma occur during pregnancy? Please describe selections above or other trauma.

_____

_____

48) When the child was born, which of the following occurred? Check all that apply.

_____ Full term
_____ Premature
_____ Vaginal delivery
_____ Surgery
_____ Cesarean section
_____ Fetal distress
_____ Lengthy labor
_____ _____

Birth Through 2 Years of Age

Birth weight: _____ lbs. _____ oz.

49) Please list any issues that arose after the child's birth.

_____

50) Indicate any major family events during this time. Check all that apply and list the child's age and general reaction.

_____ Deaths: _____
_____ Births: _____
_____ Parental conflict: _____
_____ Change of residence:_____
_____ _____
_____ Change in primary caretaker: _____
_____ Traumatic events: _____
_____ Posttpartum depression/anxiety: _____
_____ Separation from parents: _____
_____ _____

51) Has the child experienced emotional, physical, sexual abuse and/or neglect during this time? _____ Yes _____ No

If yes, explain _____

52) What was the child like as a baby and as a toddler? Check all that apply.

_____ Cuddly
_____ Difficult to sooth
_____ Experienced reflux
_____ Fussy
_____ Slow to adjust to change
_____ Separation anxiety
_____ Social
_____ Poor sleeper
_____ Poor eye contact
_____ Quiet
_____ Poor eater

53) Was the child breastfed, bottle fed, or other?_____

54) At what age did the child:

_____ Smile _____ Sit up without assistance _____ Crawl _____ Say first word
_____ Speak in sentences _____ Walk without support

55) Were any developmental delays noted in the child? _____ Yes _____ No

If yes, explain _____

56) Did the child receive any outside services (Birth to 3 Program, Bright Start, etc.)? *If yes, list child's age and service(s).*

_____

_____

List the age the child was toilet trained for the following: _____ Urine _____ Bowels _____ In Progress

57) Have there been any issues related to toilet training? _____ Yes _____ No

If yes, explain _____

Preschool Development (3-5 years of age) *Skip if child is under three.*

58) Indicate any major family events during this time. Check all that apply and list the child's age and general reaction.

_____ Deaths: _____ _____ Change in primary caretaker: _____
_____ Births: _____ _____ Traumatic events: _____
_____ Parental conflict: _____ _____ Postpartum depression/anxiety: _____
_____ Change of residence:_____ _____ Separation from parents: _____
_____ _____ _____ _____

59) Has the child experienced emotional, physical, sexual abuse, or neglect during this time? _____ Yes _____ No

If yes, explain _____

60) How does the child relate others (social development) within the following settings?

Home: _____ _____ Preschool: _____
Daycare: _____ _____ Playdates: _____
Other: _____ _____ Other: _____

61) Please list any unusual mannerisms, habits, or fears the child experienced during this time.

_____ _____ _____
_____ _____ _____
_____ _____ _____

62) Please list any behavioral concerns or problems the child presented during this time.

_____ _____ _____
_____ _____ _____
_____ _____ _____

63) Is this child fearful of new people and/or situations? _____ Yes _____ No

If yes, explain _____

64) Do you have any special concerns about this child during this age range? Check all that apply.

_____ Eating problems	_____ Temper tantrums	_____ Easily frustrated	_____ Toileting problems
_____ Toileting problems	_____ Quiet	_____ Clumsy	_____ Sleeping problems
_____ Accident prone	_____ Often sad or angry	_____ Bed wetting	_____ Overactive
_____ Poor eye contact	_____ Speech problems	_____ Demanding	_____ Bonded or attached difficult

Elementary/School-Age Development (6-12 years of age) *Skip if child is under six.*

65) Indicate any major family events during this time. Check all that apply and list the child's age and general reaction.

_____ Deaths: _____
_____ Births: _____
_____ Parental conflict: _____
_____ Change of residence:_____
_____ _____
_____ Change in primary caretaker: _____
_____ Traumatic events: _____
_____ Postpartum depression/anxiety: _____
_____ Separation from parents: _____
_____ _____

66) Has the child experienced emotional, physical, sexual abuse, or neglect during this time? _____ Yes _____ No

If yes, explain _____

67) Please list any unusual mannerisms, habits, or fears the child experienced during this time.

_____ _____ _____
_____ _____ _____

68) Please list any behavioral concerns or problems the child presented during this time.

_____ _____ _____
_____ _____ _____

69) Has the child engaged in any self-injuring behaviors? _____ Yes _____ No

If yes, explain _____

70) Has the child ever threatened to kill or harm others? _____ Yes _____ No

If yes, explain _____

School History

71) Please note any difficulties the child has experienced in the following areas:

	Academics	*Socialization*	*Behavior*	*Other*
Kindergarten	_____	_____	_____	_____

	Academics	*Socialization*	*Behavior*	*Other*
First Grade	_____	_____	_____	_____
Second Grade	_____	_____	_____	_____
Third Grade	_____	_____	_____	_____
Fourth Grade	_____	_____	_____	_____
Fifth Grade	_____	_____	_____	_____
Sixth Grade	_____	_____	_____	_____

72) Is the child on an IEP or 504 Plan? _____ Yes _____ No

If yes, explain _____

73) Have any disciplinary actions been taken (detention, suspension, or expulsion)? _____ Yes _____ No

If yes, explain _____

74) Is the child involved in any extracurricular activities? _____ Yes _____ No

If yes, list _____

Adolescent Development (13-18 years of age) *Skip if child is under thirteen.*

75) Indicate any major family events during this time. Check all that apply and list the child's age and general reaction.

_____ Deaths: _____
_____ Births: _____
_____ Parental conflict: _____
_____ Change of residence: _____
_____ _____
_____ Change in primary caretaker: _____
_____ Traumatic events: _____
_____ Postpartum depression/anxiety: _____
_____ Separation from parents: _____
_____ _____

76) Has the child experienced emotional, physical, sexual abuse, or neglect during this time? _____ Yes _____ No

If yes, explain _____

77) Please list any unusual mannerisms, habits, or fears the child experienced during this time.

_____ _____ _____
_____ _____ _____

78) Please list any behavioral concerns or problems the child presented during this time.

_____ _____ _____
_____ _____ _____

79) Has the child engaged in any self-injuring behaviors? _____ Yes _____ No

If yes, explain _____

80) Has the child ever threatened to kill or harm others? _____ Yes _____ No

If yes, explain _____

81) Is the child on an IEP or 504 Plan? _____ Yes _____ No

If yes, explain _____

82) Have any disciplinary actions been taken (detention, suspension, or expulsion)? _____ Yes _____ No

If yes, explain _____

83) Please note any difficulties the child has experienced in the following areas:

	Academics	*Socialization*	*Behavior*	*Other*
Seventh Grade	_____	_____	_____	_____
Eighth Grade	_____	_____	_____	_____
Ninth Grade	_____	_____	_____	_____
Tenth Grade	_____	_____	_____	_____
Eleventh Grade	_____	_____	_____	_____
Twelfth Grade	_____	_____	_____	_____

84) Is the child involved in any extracurricular activities? _____ Yes _____ No

If yes, list _____

85) Is the child employed? _____ Yes _____ No *If yes, list employer and hours worked weekly.*

_____

86) Is the child experiencing any legal problems? _____ Yes _____ No

If yes, explain _____

At-Risk Behavior in Adolescence

87) How much time does the adolescent spend watching TV, playing video games, texting, or using a tablet or computer?

Per Day *Per Week* *Per Month*

_____ _____ _____

88) Currently or in the past has the adolescent been involved in the following that you know of or suspect?

_____ Sexually active
_____ Sexually-transmitted disease
_____ Self-injury (cutting, burning, etc.)
_____ Rape
_____ Sexting
_____ Childbirth
_____ Views pornography
_____ Displays significant interest in the same sex
_____ _____
_____ Cyber bullying
_____ Dating relationship
_____ Sexual assault
_____ Dating violence
_____ _____
_____ Appears confused about gender and/or sexuality
_____ Pregnancy
_____ Abortion
_____ _____

89) Please list any chemical substances you know, or suspect, this adolescent has consumed.

_____

_____

Additional comments, notes, or questions for the therapist: