Psychological Resource Group
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Developmental History Form

Patient Name ______________________________ Date ________________________

Address ___________________________________ City, State, Zip ____________________________

Date of birth ______________________________ Gender ☐ Male ☐ Female

Age _______________________________________ Grade ______________________

School ____________________________________ Teacher ______________________________

Referral Information

Who referred you to our service?____

Name of person completing this form ____

Relationship to child ____

Why are you here today? ____

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What kind of services are you seeking (i.e. testing, diagnosis, school programming changes, etc)?

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Parents

Mother's name ____

Address ___________________________ City ____________________ State _____ Zip _______

Phone (H) _______________________ (W) ____________________ (C) ____________________

Occupation ____________________________ Highest grade Completed _____________________

Father's name ____

Address ___________________________ City ____________________ State _____ Zip _______

Phone (H) _______________________ (W) ____________________ (C) ____________________

Occupation ____________________________ Highest grade Completed _____________________

Has this child ever experience and parental separations, divorce or death? ☐ Yes ☐ No

If yes, please indicate which, and report how old your child was at this time. __________________

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Does this child have other parents or stepparents? ☐ Yes ☐ No

If yes, please indicate ____

Siblings

Name	Age	Sex	Relationship to this child	Living at home
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Child Information

What do you enjoy most about your child? ____

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What do you find most difficult about raising this child?____________________________________

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What level of education do you hope this child will complete? (check one)

☐ High School ☐ Technical or Vocational School ☐ College ☐ Law, Medical or other _________

Indicate if you have ever had any concerns about your child in the following areas (check all that apply):

☐ Attention span
☐ Activity level
☐ Impulse control
☐ Organization/planning
☐ Memory
☐ Academic progress
☐ Social skills
☐ Social or separation anxiety
☐ Seems unhappy or irritable most of the time
☐ Worries or frets often; nervous
☐ Moody
☐ Easily upset or angered
☐ Aggression
☐ Intellectual Ability
☐ Attitude/cooperation
☐ Obsessive/compulsive or ritualistic behavior
☐ Risk-taking behavior, delinquency, and/or use of drugs/alcohol/sexual
☐ Unusual/atypical behavior or thoughts (please describe) ________________________________

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☐ Other, please describe ____

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____

Pregnancy

Were there any complications during pregnancy with this child (early labor, bleeding, maternal high blood pressure, maternal injury, etc)? ☐ Yes ☐ No

If yes, please describe ____

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Was any prescription medicine taken during pregnancy? ☐ Yes ☐ No

If yes, please indicate ____

Describe alcohol use during pregnancy ____

Describe any other drug use during pregnancy ____

Birth/Delivery

Mother's age at child's birth ___________________

Length of Pregnancy ________________________ Birth weight ______________________________

Describe the child's condition at birth ____

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Please describe any problems at birth (cesarean sections, use of forceps or suctions, lack of oxygen, etc.

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Was supplemental oxygen given to the child? ☐ Yes ☐ No

Did the child stay in the neonatal intensive care unit (NICU)? ☐ Yes ☐ No If yes, how long? _______

Comments ____

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Development

Check any areas that you have been concerned about for this child – either now or when this child was younger.

- ☐ Slow fine motor development
- ☐ Slow gross motor development
- ☐ Slow language development
- ☐ Unclear Speech
- ☐ Cognitive or intellectual development
- ☐ Social/Emotional connection
- ☐ Feeding or weight gain
- ☐ Self care skills
- ☐ Physical growth/development
- ☐ Sleep (problems falling and/or staying asleep)
- ☐ Regression in previously mastered skills
- ☐ Sensory sensitivity

Medical/Neurological History

Does this child have a medical diagnosis at this time? ☐ Yes ☐ No

If yes, please indicate ____

Has your child experienced any of the following problems? (Check all that apply)

☐ Head injury: Describe age and circumstance ______________________________

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- ☐ Loss of consciousness
- ☐ Sustained high fever
- ☐ Seizure or convulsion
- ☐ Cancer
- ☐ Fainting spells
- ☐ Motor tics (eye blinking/rolling, shoulder shrugs, grimacing, etc)
- ☐ Vocal tics (repetitive sniffing, throat clearing, tongue licking, etc)
- ☐ Encephalitis or meningitis
- ☐ Lack of oxygen (near drowning, heart failure)
- ☐ Exposure to toxins (i.e. lead poisoning)

Please describe any serious illnesses, hospitalizations, or operations:

Illness/Operation	Age
______________________________________	________________
______________________________________	________________
______________________________________	________________
______________________________________	________________

Has this child been on any long-term prescription medications (i.e. longer than 3 months)? ☐ Yes ☐ No

If yes, when and what kind? ____

Has this child been on any other prescription medication? (i.e. for depression, anxiety, attention problems?) ☐ Yes ☐ No

If yes, when? ____________________________ What kind? ______________________________

____________________________ ______________________________

Does your child have a hearing or vision impairment? ☐ Yes ☐ No

If yes, please describe ____

____

Medical Care

Child's primary physician ______________________________ Phone number ____________________

List any other medical providers for your child ____

____

Has this child ever had a psychological evaluation, therapy, or counseling? ☐ Yes ☐ No

If yes, please describe when and for what purpose ____

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Family Health

Have any biological family members (other than the child) had any of the following? Check all that apply and indicate the family member's relationship to this child (grandparents, aunts, uncles, siblings, 1st cousins):

☐ Problems with attention and/or activity level ______________________________________

☐ Learning disability/special education services ______________________________________

☐ Speech/cognitive delays ______________________________________

☐ Cognitive/intellectual delays ______________________________________

☐ Behavior disorder ______________________________________

☐ Depression ______________________________________

☐ Anxiety ______________________________________

☐ Obsessive/compulsive behaviors ______________________________________

☐ Seizures or epilepsy ______________________________________

☐ Tic Disorder or Tourette's Syndrome ______________________________________

☐ Psychiatric Illness (bipolar disorder, schizophrenia, etc.) ______________________________________

☐ Addictions (alcohol and chemical ______________________________________

☐ Explosive Anger ______________________________________

Friendships

Please indicate how this child relates to other children.

Has problems relating to or playing with other children? ☐ Yes ☐ No

If yes, please describe ____

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Fights frequently with friends ☐ No ☐ Yes ________________________________

Prefers playing with younger children ☐ No ☐ Yes ________________________________

Has difficulty making friends ☐ No ☐ Yes ________________________________

Has difficulty keeping friends ☐ No ☐ Yes ________________________________

Prefers playing alone ☐ No ☐ Yes ________________________________

Has trouble understanding social rules ☐ No ☐ Yes ________________________________

Is teased or victimized ☐ No ☐ Yes ________________________________

Is perceived as odd by peers ☐ No ☐ Yes ________________________________

Lies/tells stories ☐ No ☐ Yes ________________________________

Blames others ☐ No ☐ Yes ________________________________

Education

Did this child attend preschool? ☐ Yes ☐ No

Any problems in preschool? ☐ Yes ☐ No If yes, please describe __________________________

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Any problems in kindergarten? ☐ Yes ☐ No If yes, please describe __________________________

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Has your child ever been assessed for special education services in school (IEP)? ☐ Yes ☐ No If yes, when and in what areas? ____

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Has your child ever had a 504 Accommodation Plan? ☐ Yes ☐ No If yes, when and for what purpose?

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If your child is in elementary school or above, estimate your child's performance across these areas by placing an 'X' in the appropriate column.

Subject	Far Below Grade Level	Somewhat below grade	At Grade Level	Somewhat Above Grade Level	Far Above Grade Level
Reading					
Handwriting					
Written Expression					
Math					
Science					
Social Studies					

Has your child ever repeated a grade? ☐ Yes ☐ No

Has your child ever undergone psycho-educational testing through the schools? ☐ Yes ☐ No

Does your child enjoy going to school? ☐ Yes ☐ No

Is your child absent from school often? ☐ Yes ☐ No

Has tardiness been a problem? ☐ Yes ☐ No

Does your child have any problems organizing materials, keeping track of assignments, or completing/turning in work on time? ☐ Yes ☐ No

Additional Comments (other concerns you may have at home or in the community regarding how your son or daughter is functioning)

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