



CHILD AND ADOLESCENT DEVELOPMENTAL AND MEDICAL HISTORY PARENT/GUARDIAN REPORT FORM

3-Hole 1/4 4 1/4 c-to-c

I. PREGNANCY AND DELIVERY:	
Length of Pregnancy (i.e. Full term, number of weeks at birth)	
Length of Delivery (# of hours from initial labor pains to birth)	
Mothers age when child born	
Child's birth weight	

II. CONDITIONS DURING PREGNANCY / DELIVERY:			
Bleeding?	YES	NO	Used alcoholic beverages? If Yes, number of drinks per week: _____
Excessive weight gain (more than 30 Pounds)?	YES	NO	Smoked cigarettes? If Yes, number of cigarettes per day: _____
Toxemia / Preeclampsia?	YES	NO	Was medication used for labor pains?
Rh factor incompatibility?	YES	NO	If yes, name of medication: _____
Frequent nausea or vomiting?	YES	NO	Was delivery induced?
Serious injury or illness?	YES	NO	Was forceps used during delivery?
If Yes, diagnosis: _____			Was the delivery by Cesarean section?
Took prescription medications?	YES	NO	Other problems: please describe
If Yes, name of Medication(s): _____			
Took illegal drugs?	YES	NO	
If Yes, name of Drugs: _____			

III. CONDITIONS AT DELIVERY OR POST BIRTH:			
Injury during delivery?	YES	NO	Was jaundiced, turned yellow?
Cardiac distress during delivery?	YES	NO	Had an infection?
Delivered with cord around neck?	YES	NO	Had seizures?
Had trouble breathing following delivery?	YES	NO	Was given medications?
Needed oxygen?	YES	NO	Born with a congenital defect?
Was cyanotic, turned blue?	YES	NO	Was in the hospital for more than 7 days?

IV. INFANT HEALTH AND TEMPERAMENT (FIRST 12 MONTHS OF LIFE):			
Was your child difficult to feed?	YES	NO	Was your child affectionate?
Was your child difficult to get to sleep?	YES	NO	Was your child sociable?
Was your child cocky?	YES	NO	Was your child easy to comfort?
Was your child difficult to put on a schedule?	YES	NO	Was your child difficult to keep busy?
Was your child alert?	YES	NO	Was your child overactive, in constant motion?
Was your child cheerful?	YES	NO	Was your child very stubborn, challenging?

V. EARLY DEVELOPMENTAL HISTORY:			
Age when child sat up without help?			
Age when child began crawling?			
Age when child began walking alone without assistance?			
Age when child began using single words? (e.g. Mama, Dada, Ball, etc...)			
Age when child began putting two or more words together?			
Age when child began bowel training... day and night	D =		N =
Age when child began bladder training... day and night	D =		N =

VI. HEALTH HISTORY:
What was the date of your child's last physical exam: _____ **Name of the doctor:** _____
Phone number of the doctor: _____

At any time, has your child had the following? Circle one.	Never	Past	Present
Asthma			
Allergies			
Chronic illness (e.g. Diabetes, Arthritis)			
Epilepsy or seizure disorder			
Febrile seizures			
Chicken Pox or other common childhood illnesses			
Heart or blood pressure problems			
High Fevers (over 103° F)			
Broken bones			
Severe cuts requiring stitches			
Head injury with loss of consciousness			
Surgery			
Lengthy hospitalization			
Lead poisoning			
Speech or language problems			
Chronic ear infections			
Hearing difficulties			
Eye or Vision problems			
Fine motor/handwriting problems			
Gross motor difficulties, clumsiness			
Appetite problems (Undereating or Overeating)			
Sleep problems (falling asleep, staying asleep, nightmares)			
Soiling problems			
Wetting problems			
Other health difficulties: PLEASE DESCRIBE: _____	Never	Past	Present

VII. IMMUNIZATION HISTORY: *Please attach the immunization record or fill in immunization history with dates.*

Psychiatrist / Therapist	Date	Parent/Guardian	Date