Victoria Grinman, LICSW
Growing Kind Minds, LLC
20 Hope Ave. #111
Waltham, MA 02453
Tel: 646.522.0628

Developmental History Form

Date ____/____/____

Child's Name __________________________Date of Birth ____/____/____ Age ____

Street Address ____

Town ________________________________ Zip Code ___________________

Home Telephone (_____) ___________________ Work (____) _________________

Cell (____) _________________ Email ______________________________

Person completing this form ____

Who suggested therapy? ____

DEVELOPMENTAL HISTORY

Is the child your: Biological child________

Adopted child ________ Age when placed _________

Step child ________ Known since age __________

Other ________

At time of pregnancy with this child: Mother's age _______ Father's age _______

Where there any problems during pregnancy? _________________________________

Where there any problems during labor/delivery? ______________________________

Length of pregnancy: _________ weeks

Baby's health at time of birth: Weight ________

Trouble breathing_______ Jaundice (yellow)______

Seizures ________ Fever ________

Other difficulties as newborn: _______________________________

Did your child have any of the following difficulties:

Client's Name ___________________________

	0-3 months	3-12 months	1-3 years	3-06 years	6+ years	currently
Difficult to Comfort						
Difficult to Feed						
Fears/Worries						
Sleep Problems						
Over Active						
Temper Tantrums						

How old was your child when s/he:

Walked without help ____ Spoke first word _____

Spoke 2-3 word sentences ____ Toilet Trained _____

Are there unusual or traumatic circumstances that affected your child's development?

___Yes ___No If yes, please describe: ____

Has there been history of child abuse? ___Yes ___ No

If yes, which type(s)? ___ Sexual ___ Physical ___ Verbal

Other childhood issues: ___ Neglect ___ Inadequate Nutrition ___ Other (please specify):

____

SCHOOL HISTORY

Did your child attend preschool/daycare? Yes ___ No ___ Age s/he began____

Where there any concerns at the time your child entered kindergarten? ___Yes___No

If yes, please describe: ____

Please list the schools your child has attended:

School _____________Grades ______ Reason for termination _________________

School _____________Grades ______ Reason for termination _________________

School _____________Grades ______ Reason for termination _________________

Client's Name ___________________________

Has your child been evaluated? Yes ____ No ____

If yes, please specify when and where: ______________________________________

Does your child have an IEP? Yes ____ No ____

If yes, please describe: ____

How old was your child when school difficulties were first noticed? ________________

Please describe: ____

Does your child feel unhappy about going to school? Yes ___ Sometimes ____ No ____

SOCIAL HISTORY

Has your child had any difficulties separating from familiar people? Yes ___ No __

If yes, please describe: ____

Has your child experienced any major losses and/or separations? Yes ___ No __

If yes, please describe: ____

Does your child play with children his/her age? Yes ___ No __

Please describe: ____

Please describe any problems your child may have with relationships: _____________

____

How would you describe your child when s/he interacts with other people: (check all that apply)

___Affectionate ___Aggressive ___Avoidance ___Fight/Argue Often

___Follower ___Friendly ___Leader ___Outgoing

___Shy/Withdrawn ___Submissive ___Other (specify): ________________

Client's Name ___________________________

HEALTH INFORMATION

Please indicate if your child experiences any of the following health concerns and describe the nature of the problem:

Allergies ____

Asthma ____

Stomachaches ____

Headaches ____

Seizures ____

Ear Infections ____

Vision Problems ____

MEDICATIONS

Prescribed meds	Dose	Purpose	Side effects
________________________	_______	_______________	________________
________________________	_______	_______________	________________
________________________	_______	_______________	________________
________________________	_______	_______________	________________

Over-the-counter	Dose	Purpose	Side effects
________________________	_______	_______________	________________
________________________	_______	_______________	________________

Is your child allergic to any medications or drugs? ___Yes ___No If yes, describe:
____

MEDICAL/DENTAL CARE

	Date	Reason	Results
Last physical exam	________	____________________	_______________
Last doctor's visit	________	____________________	_______________

Client's Name ___________________________

	Date	Reason	Results
Last dental exam	________	____________________	_______________
Most recent surgery	________	____________________	_______________

Family history of medical problems: ____

Pleases check if there have been any recent changes in the following:

__ Sleep patterns __Eating patterns __ Behavior __Energy level

__ Physical activity level __General disposition __ Weight __Tension

Describe changes in the areas you checked above:

____

NUTRITION

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	_______ / week	_____________________	___Low ___ Med ___High
Lunch	_______ / week	_____________________	___Low ___ Med ___High
Dinner	_______ / week	_____________________	___Low ___ Med ___High
Snacks	_______ / week	_____________________	___Low ___ Med ___High

COUNSELING/TREATMENT HISTORY

Information about your child (past and present):

	Yes	No	When	Where	Experience
Counseling/Psychiatric					

Treatment	____	____	_______	_______________	_________________
Hospitalizations	____	____	_______	_______________	_________________
Suicidal attempts	____	____	_______	_______________	_________________
Drug/alcohol treatment	____	____	_______	_______________	_________________
Involvement with self-help groups (e.g., AA, NA, OA)	___	___	_______	_____________	_________________

Client's Name _________________________

Information about family (past and present):

	Yes	No	When	Where	Who
Counseling/Psychiatric Treatment	____	____	_______	_____________	_________________
Hospitalizations	____	____	_______	_____________	_________________
Suicidal attempts	____	____	_______	_____________	_________________
Drug/alcohol treatment	____	____	_______	_____________	_________________
Involvement with self-help groups (e.g., AA, NA, OA)	___	___	_______	_____________	_________________

FAMILY INFORMATION

Relationship	Name	Age	Living		Living w/ child		#Days/week
Mother	________________	______	Yes	No	Yes	No	_________
Father	________________	______	Yes	No	Yes	No	_________
Sibling	_________________	______	Yes	No	Yes	No	_________
Sibling	_________________	______	Yes	No	Yes	No	_________
Sibling	_________________	______	Yes	No	Yes	No	_________

Significant others (grandparents, step-relatives, half-relatives):

Relationship	Name	Age	Living		Living w/ child		#Days/week
___________	_________________	_____	Yes	No	Yes	No	_________
___________	_________________	_____	Yes	No	Yes	No	_________
___________	_________________	_____	Yes	No	Yes	No	_________

If divorced, what is your custody agreement: Legal___________ Physical __________

How old was your child at the time of: Separation __________ Divorce _________

Is either parent in a committed relationship? Yes ____ No ____

Please describe: ____

____

Client's Name __________________________

Please list any relatives who have experienced any of these difficulties. Please include information regarding parents, siblings, grandparents, aunts, uncles, and cousins:

Attention Deficit Hyperactive Disorder_________________________ __________

Learning Difficulties ____

Behavior Problems ____

Developmental Delays ____

Depression ____

Anxiety ____

Alcohol/Drug Problems ____

Other ____

ADDITIONAL AREAS OF CONCERN:

Please check behaviors and symptoms that occur to your child more often than you would like them to take place:

_______ Aggression
_______ Phobias/fears
_______ Fatigue
_______ Anger
_______ Anxiety
_______ Avoiding people
_______ Hopelessness
_______ Impulsivity
_______ Elevated mood
_______ Alcohol dependence
_______ Recurring thoughts
_______ Antisocial behavior
_______ Sick often
_______ Sleeping problems
______ Speech problems
______ Suicidal thoughts

________ Depression
_______Disorganized thought
________ Distractibility
________ Withdrawing
________ Drug dependence
________ Eating disorder
________ Other (specify):

________ Irritability
_______ Judgment errors
________ Loneliness
________ Worrying
________ Mood shifts
_______ Panic attacks
____

Client's Name ____________________________

Briefly discuss how the above symptoms impair your child's ability to function effectively:
____

____

Any additional information that would assist us in understanding your concerns or problems:
____

____

____

____

What are your goals for therapy?
____

____

Do you anticipate any obstacles to your child's participation in therapy?___Yes___No
If yes, explain:

Does your child feel suicidal or self-destructive at this time? ___Yes ___No
If yes, explain:

Does your child feel homicidal at this time? ___Yes ___No
If yes, explain:

Please list your child's strengths and interests:

Thank you for having taken the time to answer these questions.
Your responses will help me to help you and your child.