Conlon Psychological Services, PLLC
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DEVELOPMENTAL HISTORY

INSTRUCTIONS: To assist us in helping your family, please fill out this form as fully and openly as possible. Your answers will help plan a course of therapy that is most suitable for your child and your family. Several of your answers on this form may be shared with your child or your child's other parent if you give us permission to share this information. For this reason you are advised to respond honestly and carefully to each item. If certain questions do not apply to you or you do not want to share this information, please leave them blank.

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Gender: _____

Place of Birth: _____ Grade: _____

Current Age: _____ Child's School: _____

Home Address: _____ Home phone: _____

City/State/Zip: _____

Briefly state your main concerns or the reason you came in today: _____
_____
_____

FAMILY BACKGROUND:

Child is presently living with:

- ☐ Natural mother
- ☐ Natural father
- ☐ Stepmother*
- ☐ Adoptive mother
- ☐ Adoptive father
- ☐ Stepfather
- ☐ Foster mother
- ☐ Foster father
- ☐

Siblings & age(s): _____

Others living in the home & ages: _____

Is this your first marriage?: Yes _____ No _____

If No, which marriage is it for you?: 2 3 4 5+

How long have you and your present spouse been married? _____

If you are no longer living with your child's biological parent, please supply the following:

Year of marriage _____ Year of separation/divorce_____

Age of child at the time____ Grade in school_____

CHILD CARE:

Who cares for this child when caregivers are gone? _____
How many hours per day is this child in a child-care setting? _____
How many different people care for this child? (Please explain) _____

FAMILY HISTORY

	Mother	Maternal Relatives	Father	Paternal Relatives	Siblings	Other
Name						
Occupation						
Age at time of child's birth						
Highest grade completed						
Learning problems						
Attention problems						
Emotional problems						

PREGNANCY Complications

☐ Excessive vomiting ☐ hospitalization required ☐ length of stay

☐ Excessive staining/blood loss ☐ threatened miscarriage ☐ toxemia

Infection(s) specify: _____
Operation(s) specify: _____
Smoking during pregnancy _____# cigarettes per day
Alcohol consumption during pregnancy _____
Drug use during pregnancy (specify) _____
Medications taken during pregnancy (specify) _____
X-rays during pregnancy (specify) _____
Duration of pregnancy: _____ weeks

DELIVERY

Type of labor: Duration (Hrs)_____ ☐ Spontaneous ☐ Induced

Type of delivery: ☐ Normal ☐ Breech ☐ Cesarean

Complications ☐ Cord around the neck ☐ Hemorrhage ☐ Other (specify)_____

Birth weight: _____ lbs. _____ oz. APGAR score _____

INFANCY PERIOD:

Were any of the following present – to a **significant** degree—during the first few years of life? If so, describe:

☐ Did not enjoy cuddling	☐ Diminished sleep
☐ Difficult to comfort	☐ Frequent head banging
☐ Excessive restlessness	☐ Difficulty nursing
☐ Constantly into everything	☐ Colic
☐ Was not calmed by being held or stroked	

Describe any of the above: _____

PRESENT MEDICAL STATUS:

Child's physician: _____ Telephone: _____
Address: _____
How often does this child see a doctor? _____ Date of last visit: _____
Present illnesses for which the child is being treated (if any): _____
Is this child currently on medication? ____ No ___ Yes
If yes, indicate type and reason: _____

MEDICAL HISTORY:

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood Diseases	**Age**	**Complications**
Hospitalizations		
Operations		
Head Injuries		
Seizures/convulsions		
Coma		
Eye Problems	With Correction	Date of most recent exam
Ear Problems	With Correction	Date of most recent exam
Poisoning		
Sleep problems		
Appetite		
Persistent high fevers		
Asthma		Medications:
Frequent colds		
Chronic cough		
Hay fever/allergies		
Sinus condition		
Shortness of breath during exertion		
Heart condition		
Excessive vomiting		
Heart murmur		
Frequent diarrhea		
Constipation		
Stomach pain		
Urination in pants/bed		
Pain while urinating		
Excessive urination		
Strong odor to urine		
Muscle pain		
Clumsy walk		
Poor posture		
Other muscle problems		
Frequent rashes		
Bruises easily		
Sores		
Severe acne		
Itchy skin (eczema)		
Bites nails		
Speech defect		
Accident prone		
Sucks thumb		

Grinds teeth		
Has tics/twitches		
Bangs head		
Rocks back and forth		
Bowel movements in pants/bed		

Has this child ever taken medication to increase activity? ___ No ___ Yes If yes: ages: _____
Has this child ever taken tranquilizer medication? ___ No ____ Yes If yes, ages: _____

DEVELOPMENTAL MILESTONES:

Please indicate the rate at which this child achieved developmental milestones. The "Average" period is only a rough estimate of what is average since every developmental milestone actually involves a range of several months. Check "Early" or "Last" only if you are sure this child's development was different from that of most other children.

Gross Motor Skills

Sat without support	□Early	□Average (6-9 months)	□Late
Crawled	□Early	□Average (6-9 months)	□Late
Walked alone (2-3 steps)	□Early	□Average (9-18 months)	□Late

Language

Followed Simple Commands	□Early	□Average (12-18 months)	□Late
Used single-word sentences	□Early	□Average (12-18 months)	□Late

Self-help

Toilet trained	□Early	□Average (13-36 months)	□Late
Toilet training was:	□Easy	□Difficult	

COORDINATION

Please rate your child's skills in the following areas:

	Below Average	Average	Above Average
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			
Number of accidents			
Compared to peers			

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not? _____
_____

How would you rate your child's overall level of intelligence compared to other children?

□ Below average □ Above Average □ Average

SCHOOL:

Were you concerned about your child's ability to succeed in kindergarten? If so, please explain:
_____
_____

Rate your child's school experiences related to academic learning (check all that apply):

	Below Average	Average	Above Average
Nursery or Pre-School			
Kindergarten			
Elementary School			
Junior High School			
High School			

List schools attended (include month of entry if partial year):

	School	City/State	Month/Year
Started Kindergarten at:			
		(Continue on back of page if needed)	

To the best of your knowledge, at what grade level is your child functioning in the following areas:
Reading_____ Spelling _____ Arithmetic/Math _____

Current school placement:

	Regular Education	Special Education	Advanced Placement
Currently			
Previously			

If your child is currently receiving or has received special counseling or remedial work in the past, please specify:
_____
_____

Rate your child's school experiences related to behavior:

	Good	Average	Poor
Nursery or Pre-School			
Kindergarten			
Elementary School			
Junior High School			
High School			

Does your child's teacher describe any of the following as significant classroom problems?

	Current Problem	Previous Problem
Doesn't sit still in his or her seat		
Frequently gets up and walks around the classroom		
Shouts out. Doesn't wait to be called on		
Won't wait his or her turn		
Doesn't cooperate well in group activities		
Typically does better in a one-to-one relationships		
Doesn't respect the rights of others		
Doesn't pay attention during storytelling or show and tell		

Describe briefly any **other** classroom behavior problems: _____
_____
_____

Has your child ever received any of the following services: If yes, please specify the areas of need and what grade level(s) such services were in place:

- 504 Services: _____
- Special Education: _____
- Speech Therapy: _____
- Gifted/Talented: _____
- Other (please describe):_____

PEER RELATIONSHIPS

	Current		Previous	
	Yes	**No**	**Yes**	**No**
Does your child seek friendships with peers?				
Is your child sought by peers for friendship?				
Does your child play with children primarily younger than his/her own age?				
Does your child play with children primarily older than his/her own age?				
Has your child experienced any problems with peers?*				

*If "yes" was marked, please describe briefly any problems your child may have with peers: _____
_____
_____

HOME BEHAVIOR:

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his/her own age.

	Current Problem	**Previous Problem**
Fidgets with hands, feet or squirms in seat		
Has difficulty remaining seated when required to do so.		
Easily distracted by extraneous stimulation.		
Has difficulty awaiting turn in game or group situations.		
Blurts out answers to questions before they have been completed.		
Has difficulty playing quietly.		
Often talks excessively.		
Interrupts or intrudes on others, not purposeful or planned but impulsive.		
Does not appear to listen to what is being said.		
Loses things necessary for tasks or activities at home.		
Boundless energy and poor judgment.		
Impulsivity (poor self-control).		
Frustrates easily.		
History of temper tantrums.		
Temper outbursts		
Sloppy table manners		
Sudden outbursts of physical abuse of other children		
Acts like he/she is driven by a motor		
Wears out shoes more frequently than siblings.		
Excessive number of accidents.		
Doesn't seem to learn from experience.		
Poor memory.		
A "different child."		
Has problems following through with instructions (usually not due to opposition or failure to comprehend).		

Does your child create more problems, either purposeful or non-purposeful, within the home setting than his/her siblings? If so, please describe: _____
_____

Does your child have difficulty benefiting from his experiences? If so, please describe:
_____

Types of discipline you use with your child: _____
_____

Is there a particular form of discipline that has proven effective? _____

What does your child do when left to play alone? _____

How does your child react to pain? High or low tolerance? _____

Does your child have any unusual fears? _____

Describe how your child uses his/her five senses: _____

How does your child express anger? What situations trigger anger? _____

Describe any special skills or areas of unusual interest: _____

Describe your child's established routines at home. How does your child react to unexpected changes in routine?
_____

Do you consider your child depressed? __ No ___ Yes If yes, briefly describe your concerns:
_____

Do you consider your child unduly anxious? __ No ___ Yes If yes, briefly describe your concerns:
_____

Please **CHECK** any of the following which are **TRUE** about your child:

- ☐ Talks about or has attempted suicide
- ☐ Physically aggressive toward others: hits, kicks, punches, etc
- ☐ Destructive
- ☐ Cruel to animals, sets fires, steals, or has run away
- ☐ Uses illegal drugs, alcohol, or medication not prescribed to him/her

WELL-BEING AND LIFESTYLE HABITS

SLEEP:

What time does your child go to bed? _____ p.m.
Describe what your child is doing in the 30 minutes just before lights out: _____
_____
Any difficulty going to bed? __ No ___ Yes If yes, please describe:_____
_____
Does your child have difficulty falling asleep? ___ No ___ Yes If yes, when did this start? _____
Please describe what happens: _____
_____
What time does your child wake up on school days? _____ a.m.
Does your child have difficulty waking up? ___ No ___ Yes
Does your child wake up on his/her own? ___ No ___ Yes If no, who wakes him/her? _____
What time does your child wake up non-school days? _____ a.m.
Have your child's sleep habits changed in the last month? ___ No ___ Yes Please describe:
_____

APPETITE:
Your child's Height: _____ Weight: _____ BMI: __ don't know __below 25 __25-29 __ above 30

Which of the following best describes your child's weight?

□ Very underweight □ underweight □ average □ slightly overweight □ overweight □ obese

Is this an area of concern? __ No ___ Yes If yes, please describe: _____

Has your child's appetite changed in the last month? __Increased ___ Decreased ___ Stayed the same
Has your child's weight changed in the last month? __Increased ___ Decreased ___ Stayed the same

Quality of appetite:

□ Picky eater for his/her age □ Rigid food preferences □ Seeks healthy, nutritious foods □ Craves sugar □ Craves salty snacks □ Consumes lots of fruits and vegetables (3-5 per day)

ACTIVITIES: List regularly scheduled activities (other than school) that your child must attend each week, such as sports (practice & games), dance lessons, Scouts, church, physical therapy, tutoring, orthodontic appointments, or other. Please indicate the time of these events as shown in the example.

	Sun	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**
Example: Tutoring		4-4:30 pm		4-4:30 pm			

(Continue on back if needed)

TECHNOLOGY: Please check the electronic devices belonging to your child. Feel free to add others.

	□Cell phone □Smart phone	□Computer, laptop, tablet, or iPad	□HDTV □Television	□Videogame consoles or handheld devices Specify:	□iPod, MP3 player, CD player, radio or stereo
Estimated hours of use per day:					
Located in his/her bedroom overnight:					
Favorites:	App:	Facebook? Twitter? Website? Other:	Shows:	Games:	Bands/type of music:

INTERESTS AND ACCOMPLISHMENTS:

What are your child's main hobbies and interests:
_____?
_____
What are your child's areas of greatest accomplishment? _____
_____
What does your child dislike doing most? _____

_____

What school subject does your child do best? _____

Which subject does he/she like the best? _____

Which school subject is your child's most difficult? _____

Which subject does he/she like the least? _____

What are some of your child's positive contributions to your family? _____

_____

PARENT CONCERNS:

What are your goals for your child?

_____

Some behaviors you would like your child to do less often:

1. _____
2. _____
3. _____

ADDITIONAL REMARKS: Please write any additional remarks you may wish to make regarding your child.

_____

_____

_____

RECORDS

Please bring a copy of your child's most recent report card. If any psychological evaluations have been conducted please bring a copy of the psychological report if you are willing to release this information.

PLEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO THIS OFFICE AT LEAST TWO DAYS BEFORE YOUR NEXT APPOINTMENT.

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I understand that the information in this Developmental History may be shared with _____ (my child) or _____ (my child's other parent). I give Dr. Conlon permission to share this information as needed.

_____ _____

Parent/Guardian Signature Date