


Patient History Format: Child/Adolescent Development Format

Patient Name: _____ Age: ____ Sex: ____ Date of Birth: _____ Date: _____	
Were medications taken during pregnancy? <input type="checkbox"/> Yes; specify _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Has the child ever required hospitalization? <input type="checkbox"/> Yes; specify _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy? <input type="checkbox"/> Yes; specify _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	At what age did your child do the following? <i>(italicized areas reflect normal development)</i> _____ smiled (6 mths) _____ sat alone (6 to 10 mths) _____ talked in sentences (30 to 36 mths) _____ walked by self (12 mths) _____ held head up (3 to 4 mths) _____ fed self (2yrs) _____ crawled (6 to 10 mths) _____ rode a bike (6 yrs) _____ rolled over (6 mths) _____ talked in single words (18 to 24 mths) _____ pulled up (6 to 10 mths) _____ established toilet training(2 ½ to 4 yrs)
Did the birth mother experience any physical or emotional problems during pregnancy? <input type="checkbox"/> Yes; specify _____ <input type="checkbox"/> No	How would you describe your child's approach to new situations? <input type="checkbox"/> Positive, jumps right in <input type="checkbox"/> Withdrawn, tends not to participate <input type="checkbox"/> Slow to warm up; cautious
Is there any history of physical, sexual or emotional abuse? <input type="checkbox"/> Yes; specify _____ <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	How would you generally describe your child's overall mood? <input type="checkbox"/> Positive (happy, laughing, upbeat, hopeful) <input type="checkbox"/> Negative (depressed, cranky, angry, hostile) <input type="checkbox"/> Mixed but more positive, than negative <input type="checkbox"/> Mixed but more negative than positive
Was delivery normal? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Unknown <input type="checkbox"/> No; specify _____	Which school is your child currently attending? _____
What was the child's birth weight? _____ lbs. _____ oz. <input checked="" type="checkbox"/> Unknown	Is the child expected to pass this school year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did the baby experience any problems immediately after birth? <input type="checkbox"/> Yes; specify _____ <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	Is the child currently receiving special services in this school? <input type="checkbox"/> Yes; specify _____ <input type="checkbox"/> No
	Has the child ever failed a class or been held back for academic reasons? <input type="checkbox"/> Yes; specify grade: ____ <input type="checkbox"/> No