Mathers Clinic
Child & Adolescent Developmental History Form

INSTRUCTIONS:
Please complete the following information about your child and family. If any questions do not apply to your child, simply write “DNA” (does not apply) in the space provided or leave the space blank. It is best if this form is completed by all parents or primary caretakers. This information will be helpful to your child’s doctor or other professionals to better understand your child and your family.

Child’s Name: __________________________ Informant: __________________ Date: ______________

Address: ________________________________________________________________

Informant’s Relationship To Child: _________________________________________

Child’s Age: ____________________ Child’s Date Of Birth: ____________________ Gender: __________

School: __________________________ Grade: __________ Phone # Of School: ______________

Current Teacher(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I. Family Composition

Is this child your: biological child, adopted child or foster child? ________________ Other? ________________

With whom does this child live? __________________________

Who has legal custody of this child? _________________________

Names and ages of this child’s brothers and sisters or other children in the family:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
II. Current Concerns

What are you most concerned about regarding your child that has led you to complete this history form?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

III. Developmental and Medical Information

Pregnancy

Indicate any complications during pregnancy.

_________ Excessive vomiting. Was hospitalization required? __________

_________ Toxemia? Other illnesses? __________

_________ Smoking during pregnancy? Number of cigarettes smoked per day

_________ Alcohol consumption during pregnancy (if beyond an occasional drink)? __________

_________ Other drug use during pregnancy? __________

Delivery

Type Of Labor: ___________  Spontaneous: ___________  Induced Duration (Hours): ___________

Type Of Delivery: ___________ Normal  ___________ Breech  ___________ Caesarean

Complications: ___________ Cord Around Neck  ___________ Hemorrhage  ___________ Infant Injured During Delivery

Other: ___________

Birth Weight: _________ lbs. _________ oz.

Post Delivery Period

_________ Jaundice  ___________ Cyanosis (Turned Blue)  ___________ Incubator Care

Infection (Specify): ___________
Mathers Clinic Child & Adolescent Developmental History Form

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Infancy Period

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

_____ Did not enjoy cuddling. _____________________________________________________________

_____ Was not calmed by being held or stroked. ____________________________________________

_____ Difficult to comfort. ______________________________________________________________

_____ Colic. _________________________________________________________________________

_____ Excessive restlessness. __________________________________________________________________

_____ Excessively irritable. __________________________________________________________________

_____ Diminished sleep. ____________________________________________________________________

_____ Frequent head banging. __________________________________________________________________

_____ Difficulty nursing. ___________________________________________________________________

_____ Constantly into everything. __________________________________________________________

Developmental Milestones

Indicate below whether this child achieved the following developmental milestones at a normal age, early, or later than others his/her age.

Smiled: ___________ Early ___________ Normal Age ___________ Later Than Normal

Sat Without Support: ___________ Early ___________ Normal Age ___________ Later Than Normal

Crawled: ___________ Early ___________ Normal Age ___________ Later Than Normal

Stood Without Support: ___________ Early ___________ Normal Age ___________ Later Than Normal

Spoke First Words: ___________ Early ___________ Normal Age ___________ Later Than Normal

Said Phrases: ___________ Early ___________ Normal Age ___________ Later Than Normal

Said Sentences:: ___________ Early ___________ Normal Age ___________ Later Than Normal

Bladder Trained, All Day: ___________ Early ___________ Normal Age ___________ Later Than Normal

Bladder Trained, At Night: ___________ Early ___________ Normal Age ___________ Later Than Normal

Crystal Lake: 145 S Virginia St, Crystal Lake, IL 60014  phone: 815.444.9999  fax: 815.986.1363
Rockford: 6090 Strathmoor Dr, Ste 1, Rockford, IL 61107  phone: 815.444.9999  fax: 815.986.1363
Woodstock: 715 W Judd St, Woodstock, IL 60098  phone: 815.444.9999  fax: 815.986.1363
Elgin: 585 N Tollgate Rd, Ste E, Elgin, IL 60123  phone: 847.462.6099  fax: 847.628.6064
Fox Lake: 81 E Grand Ave, Fox Lake, IL 60020  phone: 224908.3005  fax: 847.531.1296
Mathers Clinic Child & Adolescent Developmental History Form

Child’s Name: ___________________________ Informant: ___________________________ Date: ___________________________

Bowel Trained: ___________ Early ___________ Normal Age ___________ Later Than Normal
Rode Tricycle: ___________ Early ___________ Normal Age ___________ Later Than Normal
Rode Bicycle (without training wheels): ___________ Early ___________ Normal Age ___________ Later Than Normal
Buttoned Clothing: ___________ Early ___________ Normal Age ___________ Later Than Normal
Tied Shoelaces: ___________ Early ___________ Normal Age ___________ Later Than Normal
Named Colors: ___________ Early ___________ Normal Age ___________ Later Than Normal
Recited Alphabet In Order: ___________ Early ___________ Normal Age ___________ Later Than Normal
Began To Read: ___________ Early ___________ Normal Age ___________ Later Than Normal

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 and complications if any) ___________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
Operations: ___________________________________________________________________________________________
Hospitalizations: ______________________________________________________________________________________
Head Injuries: _________________________________________________________________________________________
Convulsions With Fever: ___________ Without Fever ___________
Coma: ______________________________________________________________________________________________
Vision Problems: _____________________________________________________________________________________
Hearing Problems: ____________________________________________________________________________________
Allergies or Asthma: __________________________________________________________________________________
Poisoning: __________________________________________________________________________________________
Sleep Problems: ______________________________________________________________________________________
Appetite: ____________________________________________________________________________________________
Growth Problems: ____________________________________________________________________________________
Mathers Clinic Child & Adolescent Developmental History Form

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Other medical information that is relevant __________________________________________________________

______________________________________________________________

Height: ____________ Weight: ______________

Present illnesses for which the child is being treated:

____________________________________________________________________________________________

Psychotropic medications (stimulants, medications for ADHD, mood, anxiety medications) child has been taking or is currently taking. Include name of medication and dosing.

a. current medications: _________________________________________________________________

b. previous medications: _________________________________________________________________

Describe any benefit from these medications or adverse effects:

____________________________________________________________________________________________

____________________________________________________________________________________________

Has your child ever received treatment by a mental health professional? If so, who provided this treatment, when, and what was the purpose of the treatment?

____________________________________________________________________________________________

____________________________________________________________________________________________

IV. Family Information

Use the checklists below to describe any family history of psychiatric and learning problems (in child’s parents, grandparents, or siblings).

Aggressiveness, defiance: _____ Not A Problem _____ A Problem (Specify Who) _________________________

Difficulties with attention/hyperactivity as a child: _____ Not A Problem _____ A Problem (Specify Who) _________________________

Learning problems: _____ Not A Problem _____ A Problem (Specify Who) _________________________

Failed to graduate from high school: _____ Not A Problem _____ A Problem (Specify Who) _________________________

Mental retardation: _____ Not A Problem _____ A Problem (Specify Who) _________________________
Mathers Clinic Child & Adolescent Developmental History Form

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Psychosis or schizophrenia: _____ Not A Problem _____ A Problem (Specify Who) _____________________________

Depression: _____ Not A Problem _____ A Problem (Specify Who) _____________________________

Anxiety: _____ Not A Problem _____ A Problem (Specify Who) _____________________________

Tics or Tourette’s syndrome: _____ Not A Problem _____ A Problem (Specify Who) _____________________________

Alcohol abuse/substance abuse: _____ Not A Problem _____ A Problem (Specify Who) _____________________________

Antisocial behavior (assaults, thefts, etc.): _____ Not A Problem _____ A Problem (Specify Who) _____________________________

Arrests: _____ Not A Problem _____ A Problem (Specify Who) _____________________________

Physical abuse/sexual abuse: _____ Not A Problem _____ A Problem (Specify Who) _____________________________

V. School Information

List the name of each school your child has attended from preschool on.

kg: ___________________________ 7th: ___________________________

1st: ___________________________ 8th: ___________________________

2nd: ___________________________ 9th: ___________________________

3rd: ___________________________ 10th: ___________________________

4th: ___________________________ 11th: ___________________________

5th: ___________________________ 12th: ___________________________

6th: ___________________________ After 12th: ___________________________

In general, describe your child’s performance during elementary school. Go grade by grade, if necessary, and list any outstanding strengths or problems.

________________________________________________________________________

________________________________________________________________________

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Describe your child’s performance during middle school and high school. Again, go grade by grade, if necessary, and list any outstanding strengths or problems.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Has your child ever had to repeat a grade? ________________________________ If so, which grade? __________

Has your child ever received special education services? __________________________ If so, what grade? __________

Does your child currently have an IEP from his/her school? __________________________

Does your child currently have a 504 Plan at school? __________________________

Describe the main focus of your child’s IEP or 504 Plan (note accommodations your child is currently receiving).

________________________________________________________________________

________________________________________________________________________

Indicate if your child’s teacher(s) describe any of the following as significant classroom problems.

_________ Doesn’t sit still in his or her seat

_________ Frequently gets up and walks around the classroom

_________ Shouts out. Does not wait his/her turn to be called on

_________ Does not cooperate well in group activities

_________ Typically does better in a one to one relationship

_________ Does not respect the rights of others

_________ Does not pay attention during lessons

_________ Fails to finish assigned class work

_________ Bullies other children

_________ Is not sought out by others to play or work together

_________ Describe any problems your child may have in school with learning

_________ Describe any problems your child may have with homework (e.g., forgets, does not return it to school, etc.)
VI. Child Management Techniques

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem and how well do they work?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Describe any differences or similarities between each parent’s management styles in handling disruptive behavior.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Describe what steps you might take to improve your management style in handling disruptive behavior.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

VII. Strengths and Accomplishments

We realize that we have focused largely on problems that your child may be having. However, we are also quite interested in understanding your child’s strengths, talents, skills, and accomplishments. Please use the space below to describe these assets and use additional pages if necessary.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________