Uplands Counseling Associates, Inc.
CHILD AND ADOLESCENT DEVELOPMENTAL HISTORY

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

Gender: ____ Female ____Male _____Transgendered (☐ MTF ☐ FTM)

FAMILY INFORMATION:

Parent Name: _____ Age:_____ Occupation: _____

Parent Name: _____ Age:_____ Occupation: _____

Siblings Names and Ages: _____

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married
If separated, divorced, or never married, what is the legal custody/placement order? _____

_____

Are there other adults who have a significant part in raising your child? ☐ Yes ☐ No
If yes, please indicate name and relationship (step-parent, grandparent, boy/girlfriend): _____

_____

Have there been any significant changes in your family over the last few years? (Marriages, deaths, illness, births, separation/divorce, parent dating, parent job change, money problems, other) _____

_____

Adoption information if applicable: _____

HEALTH CARE:

Primary Care Physician/Health Clinic: _____

Current Health Concerns: _____

Current Medications: _____

Allergies: _____

Exercise: _____

PERINATAL HISTORY:

Pregnancy or Maternal Problems _____

Alcohol or Drug Use Concerns? _____

Delivery was healthy?_____ Complications? _____

DEVELOPMENTAL HISTORY:

Were early milestones reached at appropriate ages?

Motor Skills: _____ Speech/Language: _____

Toileting: _____ Feeding: _____

Any concerns in:	**Age when noted**:	**Any concerns in**:	**Age when noted**:
Social Skills: _____		School Success: _____	
Attention: _____		Sleep: _____	
Behavior: _____		Emotions/Mood: _____	
Sensory Function: _____			

SCHOOL HISTORY:

Current school and grade: _____ Repeated grades? _____

School Interventions /IEP/Accommodations needed (current or previous): _____

_____

Talented/Gifted Identification: _____

Behavior problems in school?: _____

Any current concerns: _____

_____

SLEEP:

Time to bed: _____ Asleep by: _____ Awake by: _____

Other sleep concerns: _____

FAMILY HISTORY:

Is there a family history for any of the following problems:

- ☐ Learning Difficulties
- ☐ Speech/Language difficulties
- ☐ Developmental Disorder
- ☐ Intellectual Disability
- ☐ Drug or Alcohol Problem
- ☐ Emotional Problems (depression, excessive anxiety,mood swings, anger issues, other)
- ☐ School Challenges
- ☐ Abuse

TEEN BEHAVIOR:

Do you have concerns about your teen using alcohol or drugs? _____

_____

Do you have concerns about any other risks/behaviors for your teen? _____

_____

Any police/Social services involvement? _____

PARENT COMMENTS:

What are your child's strengths?

What kind of discipline do you use and what works best for your child?

What are your goals for your child/family?

Is there anything else you would like us to know about your child?

Thank you for completing this form. Please bring this to your first appointment. It will become part of the treatment record.

PARENT Signature: _____Date: _____