mpa
MERIDIAN PSYCHOLOGICAL ASSOCIATES, P.C.

Date: ___________
Therapist: ___________

Child and Adolescent Developmental History Form

The purpose of this form is to obtain a detailed understanding of your child's growth and development. Please answer all of the questions below to the best of your ability. If a question does not apply to your particular situation, please leave it blank.

IDENTIFYING INFORMATION

Child's Name: ____ Today's Date: _________________________

Child's Date of Birth: __________________________________ Age: _____ Gender: ___________________

Home Address: ____

Home Phone Number: ________________________________ Cell Phone: ___________________________

PRESENTING PROBLEM

Why are you seeking this evaluation or treatment? ____

____

When did these problems begin? ____

What are your goals for this evaluation or treatment? ____

____

FAMILY BACKGROUND

Mother's Name: ____ Mother's Age: ___________

Address:____

Mother's Cell Phone: ___________________________ Work Phone: _______________________________

Mother's Email Address: _________________________________ May we use email to contact you? Yes □ No □

Occupation: ____ (Full-Time/Part-Time?) ______

Education/Highest grade completed: ____

Father's Name: ____ Father's Age: ____________

Address (if different from above):____

Father's Cell Phone: ____________________________ Work Phone: ______________________________

Father's Email Address: _________________________________ May we use email to contact you? Yes □ No □

Occupation: ____ (Full –Time/Part-Time?) ______

Education/Highest grade completed: ____

Name of Sibling	Age	Gender	Lives at home?	Quality of relationship?
1.				
2.				
3.				

*please list additional siblings on the back side of this page

Does your child have step-parents? Yes □ No □ If yes, please complete the following information:

Names(s):____

Relationship(s) with your child:____

Contact Information: ____

Is your child adopted or being raised by persons other than the biological parents? Yes □ No □

If yes, please explain: ____

Other persons living in the home:

Name: ____ Relationship to child: _______________________

Name: ____ Relationship to child: _______________________

FAMILY CIRCUMSTANCES

Who cares for your child when parents or caregivers are at work or gone? ____________________________

With whom does your child currently live? ____

Parents are: Married □ Divorced □ Separated □ Living Together □ Never Married □ Other: __________

Who has the authority to make medical and education decisions for your child? _______________________

**[Reminder: A copy of the most recent court order regarding custody arrangements and authority to consent for treatment must be on file with MPA in order to proceed with treatment.]*

If parents are not married, what is the custodial arrangement? Joint Legal □ Sole Legal □ (to whom?: _______)

If there is a custody arrangement, who has physical custody? ______________________________________

How often does the noncustodial parent see the child? ____

How often does your child visit his/her grandparents? ____

How often does your child visit extended family members or close friends? ___________________________

How many times has your family moved since your child was born? _________________________________

Family's religious affiliation (optional): ____

What is your child's racial / ethnic background? ____

Does your child experience concerns related to their racial / ethnic background (e.g., racism, discrimination, confusion about their identity, etc.)? ____

What is the primary language spoken in your home? ____

DEVELOPMENT

Did the mother receive prenatal medical care? Regular doctor visits □ Vitamins □ Other: _________________

Did the mother experience any emotional or medical difficulties during pregnancy or childbirth? Yes □ No □

If yes, please explain: ____

Length of pregnancy: _________________ Length of labor: ____________ APGAR scores: ________________

Birth weight: ____lbs. _____oz. Length: ________ Complications: __________________________________

Temperament as an infant? (e.g., easy to soothe, sleep habits, easy to schedule, cried often, etc.): ___________

____

At approximately what age did your child begin exhibiting the following behaviors:

Crawled: __________________ Sat alone: _______________ Walked Independently: _________________
First Words: ________________ Phrases: ________________ Spoke In Sentences: ___________________
Toilet Trained: ______________

Did your child experience any of the following problems during infancy or as a toddler?

Colic	Yes □	No □	Delayed Language Development	Yes □	No □
Excessive Crying	Yes □	No □	Unclear Speech	Yes □	No □
Eating Problems	Yes □	No □	Sensitivity to Noise	Yes □	No □
Delayed Fine Motor Skills (using utensils to eat, cutting with scissors)	Yes □	No □	Delayed Gross Motor Skills (running, jumping, kicking, climbing)	Yes □	No □

If yes, please explain: ____

Which hand does your child use for writing? __________ For eating? __________ For throwing?___________

Has the family recently experienced any unusual or stressful events? Yes □ No □ If yes, please explain: ____

____

For Adolescents: Age at onset of puberty: ______________ Age at first menstruation (for a girl): _____________

Does your child date? Yes □ No □ Is your child sexually active? Yes □ No □ Unsure □

Does your child make good decisions in relationships? Yes □ No □ Please explain: ___________________

____

MEDICAL AND PHYSICAL HISTORY

Name of child's primary care physician: ____

Address: ____ Phone: ________________

**[A signed consent from the custodial parent will be required for your practitioner to consult with the primary care physician]*

Date of most recent physical exam: __________________________ Results: ________________________

History of hospitalizations, ER visits, surgeries? Yes □ No □ If yes, please list: _______________________

____

Has your child experienced any of the following medical issues?

Frequent Ear Infections	Yes □	No □	Muscle Pain	Yes □	No □
Asthma	Yes □	No □	Chronic Headaches*	Yes □	No □
Allergies	Yes □	No □	Frequent Ear Infections	Yes □	No □
Glasses or Contact Lenses	Yes □	No □	Vision Problems	Yes □	No □
Gastrointestinal Problems	Yes □	No □	Hearing Problems	Yes □	No □
Concussion(s)*	Yes □	No □	Seizures*	Yes □	No □
Anxiety	Yes □	No □	Congenital Problems	Yes □	No □
Depression	Yes □	No □	Repetitive Behaviors (Head banging, rocking, counting, etc.)	Yes □	No □

*If your child has experienced chronic headaches, concussions and/or seizures, please describe when and how they were treated, as well as the outcome of treatment: ____

____

Please list any other health concerns: ____

____

MEDICATION

Is your child currently taking any kind of medication? Yes □ No □

If yes, indicate name, dosage, and reason for medication: ____

____

Please list any side effects that your child may be experiencing: _______________________________________

ALCOHOL OR DRUG USE

Does your child use alcohol or drugs? Yes □ No □ Unsure □

If yes, please explain (i.e., when use started, how often, last use, trouble with law/job/school as a consequence):

____

____

PREVIOUS EVALUATIONS

Has your child ever had any of the following evaluations?

Psychological or Psychiatric evaluation Yes □ No □ Date of evaluation: ____________________________

Name of evaluator: __________________________ Reason for evaluation: ______________________________

Neurological evaluation: Yes □ No □ Date of evaluation: ____________________________

Name of evaluator: __________________________ Reason for evaluation: ______________________________

School or Academic evaluation: Yes □ No □ Date of evaluation: ____________________________

Name of evaluator: __________________________ Reason for evaluation: ______________________________

PSYCHOTHERAPY TREATMENT HISTORY

Has your child ever received counseling or other psychiatric treatment? Yes □ No □

If yes, indicate dates, name of treating professional, reason for treatment, and outcomes of treatment:

____

____

FAMILY HEALTH

Mother's present health: ____

Father's present health: ____

Has anyone in your family experienced a psychological or educational problem, such as intellectual impairment, learning disabilities, schizophrenia, depression, autism spectrum disorder, or bipolar disorder? Yes □ No □

If yes, please explain: ____

Has anyone in your family experienced suicidal thoughts or attempted suicide? Yes □ No □

If yes, who?: ____

SOCIAL HISTORY

How does your child relate to other children? ______________________________

Does your child have a best friend? Yes □ No □ How many friends does your child have? ________

How well do you know your child's friends? ______________________________

RECREATIONAL INTERESTS

Does your child participate in sports or recreational activities outside of school? Yes □ No □

If yes, please describe: ______________________________

What does your child like to do in his/her free time? ______________________________

Have your child's interests in these activities changed recently? Yes □ No □

If yes, please explain: ______________________________

What are your family's favorite activities? ______________________________

BEHAVIORAL SYMPTOMS

Does your child have difficulty with any of the following? If yes, please explain.

Meeting new people; is shy or withdrawn	Yes □	No □	Is overly anxious	Yes □	No □
Seems sad or depressed	Yes □	No □	Has thoughts of suicide	Yes □	No □
Defiant or violates rules	Yes □	No □	Has conduct problems	Yes □	No □
Is physically cruel to people or animals	Yes □	No □	Is inattentive	Yes □	No □
Has problems concentrating	Yes □	No □	Is restless	Yes □	No □
Makes careless mistakes	Yes □	No □	Is frustrated easily	Yes □	No □
Has trouble playing quietly	Yes □	No □	Has eating problems	Yes □	No □
Has frequent mood shifts	Yes □	No □	Has fears or phobias	Yes □	No □
Has difficulty managing anger	Yes □	No □	Has hallucinations	Yes □	No □
Has had trouble with the law	Yes □	No □	Please explain: ______________		

____

____

EDUCATIONAL STATUS AND HISTORY

Name of current school: ______________________ Private □ Public □ Other □: ________

Teacher(s): ______________________________

School address: ______________________School phone number: ____________

[A signed consent from the custodial parent will be required for your practitioner to consult with your child's school]

Please list the names and grades of other schools that your child has attended: ______________

____

What grades does your child earn? __________ Is this a change from previous years? Yes □ No □

If yes, please explain: ______________________________

Does your child have difficulty in school or receive any special education services or accommodations (e.g., pull out/support services, 504 accommodations, IEP) at present? Yes □ No □

Has your child ever had difficulty in school or received any special education services or accommodations (e.g., pull out/support services, 504 accommodations, IEP) in years past? Yes □ No □

If yes, please indicate which schools, which grades, what services were received, and any interventions given:

____

____

If your child has or has had an IEP, what is/was their primary and secondary disabilities?

Primary: ___________________________ Secondary: _________________________________

Were these accommodations helpful? Yes □ No □

Has your child been retained/repeated or skipped grades? Yes □ No □ Which grade(s)? ____________

Does your child dislike going to school? Yes □ No □ If yes, why? ____________________________

What are your child’s favorite / least favorite subjects? _______________________________________

What is your child’s approach to schoolwork and homework (disorganized/organized, irresponsible/responsible)?

____

TRAUMA

Has your child been the victim of verbal, emotional, physical, or sexual abuse or neglect? Yes □ No □

If yes, please explain: ____

____

Has your child ever experienced a traumatic event (e.g., sudden loss of a loved one, serious accident, sexual or physical abuse, serious illness)? Yes □ No □ If yes, please explain: ___________________________

____

DISCIPLINE

How does your child respond to rules, responsibilities, and expectations? ___________________________

What type of chores is your child responsible for? ____

What type of consequences do you give to your child? ____

Do you believe that your discipline strategy is effective? ____

WORK HISTORY

Does your child have a job, or is your child involved in a vocational program? Yes □ No □

If yes, who is your child’s current employer?: ____

What is your child’s position at their job?: _____________________ Hours worked per week: __________

Does your child's job inerfere with school work or other activities? Yes □ No □ If yes, please explain: _____

____