Susan Myket, Ph.D. & Associates

Licensed Clinical Psychologists
Using Research-Supported Therapies to Enrich Families

Developmental History Form - Confidential

Client's (Child's) Name: _____

Nickname or Preferred Name: _____

Client's Date of Birth: _____ Child's Age: _____

Name of Person Filling out Form: _____Today's Date_____

Parent's Names: _____

Are you the legal guardian of this child? YES _____ NO _____

If no, who is the child's legal guardian? _____

Primary questions or concerns that are prompting the evaluation: (additional space at the end of the form)

1. _____

2. _____

3. _____

When did you first notice the concerns listed above?

_____

_____

What are some of your child's strengths & interests (favorite activities & games, etc.)?

_____

_____

_____

1415 Bond Street, Suite 127, Naperville, Illinois 60563
Phone:(630)355-9002 Fax: (630)355-901 2
www.myketandassociates.com

Who currently lives with your child?

Name	Age	Relationship to Client	Occupation or grade in school	Highest grade completed. (1-12, Bachelor's, Master's)	Any Diagnoses or Concerns

Adoption History

Was your child adopted? Yes _____ No _____ (If "No", please skip to "Pregnancy and Birth")

Place of child's birth? _____

Age when adopted? _____

Is child aware of their adoption? _____

Total number of home placements/homes in the child's lifetime? _____

Does your child have contact with his/her biological mother and/or father? _____

Pregnancy and Birth

This child was his/her mother's ____ (enter number) pregnancy.

When did mother begin receiving prenatal care? _____

List any complications during pregnancy: _____

_____

List any prescription medications, alcohol, nicotine, or illegal drugs during pregnancy:

_____

Place of Birth: _____

Was the child considered full term? Yes _____ No _____

If no, how many weeks gestation was he/she when delivered? _____

Weight at Birth: _____

Type of birth (circle): single / twin / multiple Type of delivery (circle): Vaginal / C-Section

APGAR Scores: 1 minute _____ 5 minutes _____

Please note any complications during labor: _____

_____

_____

Interventions and medication used during labor & delivery: _____

_____

_____

Interventions required for the child after birth (phototherapy, oxygen, etc.): _____

_____

Did the child spend time in the NICU following birth? Yes _____ No _____

If yes, how long did he/she spend in the NICU? _____

How long did the mother and child remain in the hospital after delivery? _____

Early Developmental Milestones

Please indicate the approximate age at which your child met the following milestones:

Smiled at caretaker _____

Laughed aloud _____

Sat unassisted _____

Crawled _____

Stood alone _____

Walked _____

First words _____

First 2-3 word phrases _____

Pretend play _____

Toilet Trained (Day) _____

Toilet Trained (Night) _____

Health History

Does your child have a history of any of the following (check if applicable and explain below):

Allergies / Restricted Diet	
Appetite Changes	
Asthma/Respiratory Problems	
Ear Infections/P.E. Tubes	
Eating/Feeding Issues	
Emergency Department Visits	
Head Injury	
Hearing Problems	
Hospitalizations	
Loss of Consciousness	
Seizures	
Sleep Problems	
Surgery	
Vision Problems	
Other:	

Please explain any checked responses above:

_____

_____

_____

_____

Medications

Name of Medication	Dose	Date Started	Date Stopped	Prescribed by:	For treatment of:

(Please use space at end of form if needed for additional medications.)

Mental Health History

Has your child been diagnosed with any of the following concerns? Please Circle Diagnoses.

	Who diagnosed this?	When diagnosed (month/year)?
Anxiety (General, Social, Separation)		
Autism Spectrum Disorder (Autism, Asperger's, Pervasive Developmental Disorder (PDD,NOS), Social Pragmatic Communication Disorder)		
Attention-Deficit/Hyperactivity Disorder (ADHD)		
Bipolar Disorder		
Conduct Disorder or Behavioral Disorder		
Depression		
Developmental Delay		
Obsessive Compulsive Disorder (OCD)		
Oppositional Defiant Disorder (ODD)		
Speech/Language Disorder		
Aproxia		
Tic Disorder		
Other (please explain):		
Other (please explain):		

To your knowledge, has your child (circle yes or no):

Used or abused alcohol?	Yes / No
Used/abused drugs (prescription or illegal)?	Yes / No
Injured him/herself (cut, burn, pick at scabs/wounds) on purpose?	Yes / No
Attempted suicide?	Yes / No
Talked about wanting to be dead?	Yes / No
Threatened to hurt other people?	Yes / No
Been the victim of aggression or violence?	Yes / No
Been physically, emotionally, or sexually abused?	Yes / No

Please explain any "Yes" responses above:

_____

_____

_____

Previous Evaluations

Has your child ever undergone a developmental, psychological, neuropsychological, educational, or psychiatric evaluation? Yes _____ No _____

Please list any previous evaluations:

Date	*Evaluator and/or Clinic name*	*Location*	*Diagnosis*	*Were you satisfied with the outcome?*

(Please bring a copy of all previous evaluation reports with you to your appointment.)

Family Mental Health History

Does anyone in your child's family have a history of the following mental health concerns? (Please check all that apply.)

Diagnosis	Father	Mother	Sibling	Grandparent	Aunt/ Uncle	Cousin	Other Family:
Alcoholism/ Alcohol Abuse							
Anxiety							
Autism Spectrum Disorder (ASD)							
Attention-Deficit/ Hyperactivity Disorder (ADHD)							
Bipolar Disorder							
Conduct Disorder							
Depression							
Developmental Delay							
Eating Disorder							
Obsessive Compulsive Disorder (OCD)							
Oppositional Defiant Disorder (ODD)							
Schizophrenia or Psychotic Disorder							
Tic Disorder							
Other:							

Education & Interventions

Has your child ever received Early Intervention Services? Yes _____No _____

If yes, starting at what age? _____

If yes, what early intervention services are/were provided? Please circle all that apply.

Occupational / Developmental / Speech / Language / Physical / Feeding / _____

Has your child ever received Applied Behavioral Analysis (ABA) Therapy?

If yes, at what age? _____ Hours per week? _____ Length of treatment? _____

Current School / District: _____

Current Grade (if summer, what grade in fall): _____

Does your child have an IEP or 504 Plan? Yes _____ No _____

If so, what is his/her eligibility category? _____

What type of classroom placement does your child have (e.g., full inclusion, self-contained, partial inclusion, etc.)? _____

What services does your child receive at school? _____

_____

_____

Does your child currently receive any private services outside of school? Yes _____ No _____

Professionals Currently Involved

Please list any professionals (e.g., counselors, therapists, speech and language professionals, occupational therapists, psychiatrists, etc.) who currently treat your child.

Service	*Professional's name*	*Location*	*How often do you meet?*	*Are you satisfied with the service?*

Additional Development and Behavior Questions

Is there anything unusual about your child's use of language?

_____

_____

_____

Is there anything unusual about your child's play skills or behaviors?

_____

_____

_____

Does your child have friends? If so, is there anything unusual about his/her friendships?

_____

_____

_____

Is your child involved in any extra-curricular or organized groups or activities?

_____

_____

_____

Does your child engage in any repetitive movements (e.g. flapping hands, rocking, banging head, etc.) with his/her body? If so, please describe.

_____

_____

_____

Does your child have any interests that are unusual, or does he/she have any interests that are very intense? If so, please describe. _____

_____

_____

Does your child seem over or under sensitive to sensory input (e.g., smell, sound, taste, feel, sight)? If so, please describe. _____

_____

_____

Please note any other concerns or questions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form. Please fax the form to your clinician at 630-355-9012 or mail the form to the address provided below prior to your appointment if possible. Otherwise, please bring the completed form to your initial appointment.

1415 Bond Street, Suite 127, Naperville, Illinois 60563
Phone:(630)355-9002 Fax:(630)355-9012
www.myketandassociates.com