

Norford Psychological Associates

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DEVELOPMENTAL HISTORY

(All information is kept strictly confidential and will not be released to anyone without your permission.)

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

School: _____ Grade: _____ Today's date: _____

Name of person completing this form: _____

WHAT ARE YOUR MAIN REASONS FOR SEEKING TREATMENT FOR YOUR CHILD/FAMILY?

1.

2.

3.

FAMILY INFORMATION

Mother's name: _____ Age: _____ Education: _____ Occupation: _____

Father's name: _____ Age: _____ Education: _____ Occupation: _____

Parent marital status (include current and prior marriages, years married):

If separated/divorced, please describe custody arrangement:

| Child's siblings: | <u>Name</u> | <u>Age</u> | <u>Where living?</u> |
|-------------------|-------------|------------|----------------------|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

DEVELOPMENTAL HISTORY (circle one)

- Sitting alone early / on time / late
- Walking alone early / on time / late
- First words early / on time / late
- Language development early / on time / late
- Speech therapy Yes / No
- Physical therapy Yes / No
- Occupational therapy Yes / No
- Significant separation problems Yes / No
- Sleep problems Yes / No
- Eating problems Yes / No
- Fine motor skill problems Yes / No
- Gross motor skill problems Yes / No

Toilet training (completed at what age: _____)

Briefly describe any difficulties:

Please describe child care history (e.g., at home, day care, preschool with extended day, etc.):

CHILD'S TEMPERAMENT (Check all time frames that apply)

| | <u>First year of life</u> | <u>This year</u> | <u>Ongoing issue over the years</u> |
|----------------------|-------------------------------|----------------------|---|
| Difficult to comfort | _____ | _____ | _____ |
| Sleep problems | _____ | _____ | _____ |
| Fussy/irritable | _____ | _____ | _____ |
| Unhappy | _____ | _____ | _____ |
| Lack of affection | _____ | _____ | _____ |
| High-energy | _____ | _____ | _____ |
| Shy/cautious | _____ | _____ | _____ |

CHILD'S SOCIAL DEVELOPMENT

Please describe your child's social behavior at school:

Please describe your child's behavior with siblings:

Please describe your child's behavior with friends around home/community/activities:

What activities does your child enjoy?

Religion: _____

Actively involved?: _____

STRENGTHS

Please describe your child's strengths:

CHILD'S ACADEMIC HISTORY

Current school: _____ Grade: _____

Address:

Phone:

Name of teacher:

Name of guidance counselor:

(*Note: No contact is made by me with school staff without your permission and request.)

(circle one)

Math Delayed / On target / Advanced

Reading Delayed / On target / Advanced

Spelling Delayed / On target / Advanced

Any grades repeated? Yes / No

Special Education Classes? Yes / No

Tutoring? Yes / No

Does your child have an IEP plan? _____ (If yes, please bring a copy to the initial evaluation)

Does your child have a 504 plan? _____ (If yes, please bring a copy to the initial evaluation)

Has your child had a Psychological Evaluation? _____ (If yes, please bring a copy to the initial evaluation)

Please indicate any problems reported by teachers this year:

Please indicate any significant problems reported by teachers in prior years:

FAMILY HISTORY

A review of family history is often very helpful in a thorough evaluation. Please think about parents, siblings, grandparents, aunts/uncles, and cousins as you fill in the chart below.

| Family Mental Health History | | |
|---|----------|--------------------------|
| Check the item if you think a family member has or had the problem. Indicate relation to child in the final column. | | |
| Illness or Problem | X | Relation to child |
| Attention Problems or "ADD" | | |
| Hyperactivity or "ADHD" | | |
| Significant Anger problems | | |
| Learning Disability | | |
| Tics or Tourette's Disorder | | |
| Special education services | | |
| Mental Retardation | | |
| Autism/Asperger's Disorder | | |
| | | |
| Depression | | |
| Manic Depressive or Bipolar Disorder | | |
| Schizophrenia | | |
| Suicide or Suicide Attempts | | |
| Deliberate Self-Harm | | |
| Psychiatric Hospitalization | | |
| Obsessive/Compulsive problems | | |
| Severe Anxiety/Fears/Phobias | | |
| Panic Attacks | | |
| Eating Disorder (Anorexia/Bulimia) | | |
| | | |
| Alcoholism | | |
| Drug Abuse | | |
| Victim of Abuse | | |
| Post Traumatic Stress Disorder | | |
| Violent or Abusive Behavior | | |
| Trouble with the Law | | |
| Other: | | |