Dr. Heather Therapy, PLLC
Developmental Form

Name of person completing this form: _____Date:_____
Child's name:_____ Birth date_____ Current age_____ Sex: M F
Child's school_____ Child's teacher _____
Grade_____ Special placement (if any) _____

Who referred you to me?_____

Briefly describe the child's problems for which you would like help.
1._____
2._____
3._____

FAMILY MEMBERS: Name Age Occupation/Grade in School
Parent/ Guardian _____
Parent/ Guardian _____
Siblings _____
_____
_____
_____
Others _____
_____

If biological parents are divorced, when was divorce? _____
Who has custody? ☐ Mother ☐ Father ☐ Joint Custody ☐ Neither
Visitation agreement: _____
Is this child adopted? ☐ No ☐ Yes, please describe the circumstances of the adoption: _____
_____

FAMILY HISTORY
Have any of the child's blood relatives (biological parents, grandparents, siblings, aunts, uncles, or close cousins) experienced the following? Please specify which relative.
☐ Reading problems_____
☐ Attention problems_____
☐ Hyperactivity_____
☐ Developmental disorders/mental retardation_____
☐ Addiction to alcohol or other drugs_____
☐ Severe depression_____
☐ Anxiety disorders_____
☐ Other significant mental illness or disorder_____
☐ Genetic syndromes_____
☐ Other_____

CURRENT FAMILY STRESSORS
Have any of the following stressful events occurred within the past 12 months?
☐ parents divorced or separated ☐ death in family ☐ changed schools
☐ family financial problems ☐ family accident or illness ☐ parent changed job
☐ family moved ☐ Other (please specify)_____

During the following periods did your child have problems with any of these?
INFANCY—first year
☐ Did not enjoy cuddling ☐ Was not calmed by being held or stroked

☐ Difficult to comfort ☐ Colic
☐ Excessive restlessness ☐ Excessive irritability
☐ Diminished sleep ☐ Frequent head banging
☐ Constantly into everything ☐ Problems with nursing or taking bottle

TODDLER – second to third year
☐ Excessively active ☐ Cranky/irritable
☐ Withdrawn/fearful ☐ Irregular patterns of sleep, appetite, habits

Was your child on time, early, or late in reaching these developmental milestones?

Sat up	☐ On time	☐ Early	☐ Late
Walked	☐ On time	☐ Early	☐ Late
Talked	☐ On time	☐ Early	☐ Late
Bladder trained--day	☐ On time	☐ Early	☐ Late
Bladder trained—night	☐ On time	☐ Early	☐ Late
Bowel trained—day	☐ On time	☐ Early	☐ Late
Bowel trained—night	☐ On time	☐ Early	☐ Late
Reading	☐ On time	☐ Early	☐ Late

COMPREHENSION AND UNDERSTANDING
Do you consider your child to understand directions and situations as well as other children his or her age?_____
If not, why not?_____
_____

How would you rate your child's overall level of intelligence compared to other children?
☐ Below Average ☐ Average ☐ Above Average

PRESENT MEDICAL STATUS
Height _____ Weight _____
Present illnesses for which the child is being treated_____
Medications child is taking on ongoing basis_____
Any physical abnormalities_____
Name of your child's pediatrician or family doctor_____

MEDICAL HISTORY
If your child's medical history includes any of the following, please note the age when the incident or illness occurred and give pertinent details:
Problems with pregnancy, labor, or delivery of child_____
Childhood diseases (describe ages and any complications)_____
_____
Operations _____
Hospitalizations for illness/surgery_____
Loss of consciousness_____
Head injuries_____
Convulsions_____
with fever_____
without fever_____
Coma_____
Persistent high fevers_____
Eye/vision problems_____
Tics (Example: eye blinking, sniffing, any repetitive, non-purposeful movements)_____
Ear/hearing problems_____
Chronic ear infections/tubes_____
Thyroid problems_____

Allergies or asthma_____
Poisoning_____
Appetite/eating problems_____
Unusual cravings_____
Speech problems_____
Sleep problems_____
Clumsy/"accident prone"_____
Problems with coordination_____
Problems with sexual development_____

THERAPY HISTORY

Has your child ever received therapy before? ☐ No ☐ Yes
If yes, please list provider, reason for treatment and outcome:_____
_____

Has your child ever taken psychiatric medication? ☐ No ☐ Yes
If yes, what was it and how long? _____

SCHOOL HISTORY

Were you concerned about your child's ability to succeed in kindergarten? If so, explain:
_____
Has your child ever had to repeat a grade? If so, when?_____
Present class placement: Regular class_____ Special class (Please specify)_____
_____

Has your child been evaluated at school for learning disabilities, emotional disturbance, academically gifted, etc.? If so, when and with what results? _____
_____

Kinds of special counseling or remedial work your child is currently receiving:_____
_____

Does your child's teacher describe any of the following as significant classroom problems:

☐ Doesn't sit still in his/her seat
☐ Shouts out
☐ Won't wait his/her turn
☐ Doesn't respect the rights of others
☐ Doesn't pay attention
☐ Does not do homework
☐ Fails to check work
☐ Excessive time to complete work
☐ Incomplete classroom work
☐ Disorganization
☐ Talks excessively
☐ Distraction
☐ Frequently gets up and walks around the classroom
☐ Doesn't wait to be called on
☐ Doesn't cooperate well in group activities
☐ Typically does better in a one-to-one relationship
☐ Forgets assignments
☐ Many careless errors
☐ Below Average math
☐ Below Average reading skills
☐ Below Average written language
☐ Below Average spelling
☐ Below Average handwriting
☐ Anxiety

SOCIAL HISTORY

Which of the following, if any, describe(s) this child's interactions with peers?

☐ No friends
☐ Few Friends
☐ Controlling
☐ Excessively shy
☐ Average number of friends
☐ Socially comfortable
☐ Aggressive
☐ Overall social
☐ Trouble keeping friends
☐ Trouble making new friends
☐ Bullying
☐ Socially awkward

Extracurricular/Group Activities: _____

ADDITIONAL REMARKS Please use the back to make any additional remarks you wish regarding your child.