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Psychotherapy

Child and Adolescent Developmental History

**Parents: Please fill out one form per child.*

Living situation

Name of Client: ______________________________________ Age: ______ D.O.B.:_______________
Client's residence (please circle):
Biological parents' home Relatives' home Foster home Adoptive home
First names and ages of those who live in the home: ____
____
____

Pregnancy and Birth

Full term: Y N Complications at birth or during pregnancy: _______________________________
____
Family structure when baby was born: ____
____

Developmental Milestones (please indicate age)

Sat-up: _______ Crawled: _______ Walked: _______ Talked: _______ Toilet trained: ________

Describe delays or complications in any of these areas: ____
____
____

Daycare or pre-school? Y N Age child started: ________ Comments: _________________________
____
____

Who was/were the child's primary caregiver(s) from birth to 3 years: _____________________________
____
____

Family history (include births, divorce, losses, transitions, remarriage, illness, moves, etc.)
____
____
____
____

History of treatment and illnesses

Any major illness/surgery: Y N Age(s):_______ Please describe: ______________________________
____
____

Current health/physical illness/medication: Y N Age(s):_______ Please describe:_________________
____
____

Any traumatic event(s): Y N Age(s): ______ Please describe: _______________________________
____
____
____
____

Any involvement with Child Protective Services: Y N Age(s):_______ Please describe:___________
____
____

Any psychiatric illness/hospitalization: Y N Age(s):_______ Please describe: __________________
____
____
____

Any psychotropic medication: Y N Age(s):_______ Please list name/dosage: __________________
____
____
____

Any substance use/abuse/dependence: Y N Age(s):_______ Please list names/amount: __________
____
____
____

Counseling

History of counseling: Y N Age(s):________________ Please circle type of treatment:

Family - Individual - Group - School - Alateen - Day Treatment - Hospital - Other

Name of prior therapists and reason for treatment: ____________________________________
____
____
____

Substance abuse treatment: Y N Age(s):_______ Please list treatment facility/dates:
____
____

School history:

School: ___________________________________ Grade: _________ Teacher: __________________

Please describe your child/teen overall experience during these school years (include typical grades, socialization, type of classes – Special Ed, GATE, etc, -- hobbies, transitions, changes):

1st – 5th Grade:____
____
____
____

School attended: ____

6th – 8th Grade:
____
____
____

School attended: ____

9th Grade and up: ____
____
____
____

School attended: ____

Describe your child/teen challenges: ____________________________________
____
____

Describe your child/teen temperament: __________________________________
____
____

Describe your child/teen successes and qualities: ___________________________
____
____

People your child/teen seems to trust and relate well with:
____
____
____

Thank you for filling out this form.
This sort of information will be extremely helpful in the development of your child/teen's treatment.

Form completed by: ____

1761 Hotel Circle Dr. South, Suite 224 - San Diego, CA 92108 (619)944-2375
www.sdpsychotherapist.com

Signature of Client (if applicable) Date

Printed Name

Signature of Parent 1 Date

Printed Name

Signature of Parent 2 Date

Printed Name

Clinician Signature Date

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