Comprehensive Counseling Care for the Family
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Child Developmental History Form (for Ages 2-17)

SECTION I. TO BE COMPLETED BY THE ADULT INITIATING COUNSELING FOR CHILD

Child's Identifying Information

Child's Name:_____Today's Date:_____

Age: _____ Date of birth: _____ Grade in school: _____

Gender: _____ SSN: _____

Form completed by (if someone other than child): _____

Address: _____

City, State, Zip: _____

List which adults are willing to part of the child's counseling? _____

_____

Who does the child currently and primarily reside with? _____

Are child's parent's divorced or separated? ? ___ Yes ___ No

Will the nature of counseling be used to help decide custody for the child? ___ Yes ___ No

Were the child's parents ever married/cohabitated? ____Yes ____ No

Is there any significant information about the child's parents' marriage, divorce/separation, or co-parenting relationship that might be beneficial for the counselor to understand to better help the child, in counseling (for example, how the child seemed to be affected by the divorce/separation) ___ Yes ___ No If Yes, describe: _____

_____

_____

Current/Significant Functioning

Have there been any significant changes or events in your child's life? (family, moving, traumas., losses, divorce/separation, deaths, new siblings, etc.) ____Yes ___No If Yes, describe: _____

_____

_____

Please describe any current concerning behaviors, habits, attitudes, or relationships of the child related to the reason the child is seeking counseling: _____

_____

_____

_____

Primary reason(s) for seeking services: (*check any that apply*)

____ Anger/Aggression ____ Anxiety ____ Poor Social Skills ____ Depression

____ Eating disorder ____ Fear/phobias ____ ADHD ____ Autism

____ Sexual concerns ____ Addictive behaviors ____ Mental confusion

____ Sleeping problems ____Alcohol/drug use ___ Problems Concentrating

____ Mood swings ____ Negative habits ____ High-risk/self-harming behaviors

____ Low Self Esteem ____ Irritability ____ Problems Sleeping/Eating

_____ Other: _____

List any helpful information to better explain the symptoms checked above:

_____

_____

_____

When did the child begin exhibiting these behaviors (checked behaviors above)?

_____

How have you tried to deal with these behaviors?

_____

_____

What has worked to improve symptoms? _____

_____

What has <u>not</u> worked? _____

_____

How would you list the definable areas for improvement concerning the child, in the order of priority? (1=most important; 3=least important)

1. _____
2. _____
3. _____

Mental Health History

List any history of mental issues/illnesses, or mental health diagnoses that occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents)

_____

_____

To your knowledge, has the child ever:

Used chemical substances? ___ Yes ___No If Yes, please explain when and describe:

_____

_____

Experienced suicidal thoughts? ___ Yes ____No If Yes, please explain when and describe:

_____

_____

Has the child received previous mental health or substance abuse treatment or counseling services?

Outpatient? ____ Yes ____ No Provider and dates: _____

Inpatient? ____ Yes ____ No Facility and dates: _____

Psychiatric care? ____ Yes ____ No Provider and dates: _____

Medical History

List any current health concerns/conditions: _____
List any recent physical changes in child: _____
List any medications the child is currently using:

Name of Medication	Current Dosage	Time per day (am/pm)	Prescribing Physician	(Purpose of Medication)

Who is your child's pediatrician, PCP, or family physician: _____
_____ Phone: _____

Developmental History

Pregnancy/Birth:

Has the child's mother had any occurrences of miscarriages or stillborns? ____ Yes ____ No

If Yes, describe when: _____

Was the pregnancy with child planned? ____ Yes ____ No

Was there anything notable about the child mother's pregnancy? (i.e., trauma, abuse, complications, ailments, life stressors, mental health issues/illnesses, substance use, losses)

_____

_____

_____

Childhood/Adolescent History:

Was there anything notable about the following developmental stages of the child) (i.e., developmental delay, diseases, trauma, losses, abuse/neglect, diagnoses, health issues, hospitalizations):

Infancy/Toddlerhood (0-5 years old): _____

_____

School age years (6-12 years old):

_____

_____

Adolescence years (13-18 years old):

_____

_____

Compared with others in the family, how would you describe your child's development, overall: ____ slow _____ average ____ fast

Academic History

Current school: _____School phone number: _____

Type of school: ___ Public _____ Private _____ Home schooled

____ Other (specify): _____

Grade: _____ Teacher:_____

Which parent mostly handles the child's school affairs: ____ Mother ____ Father ____ Both

Is the child in special education? ____ Yes ____ No In gifted program? ____ Yes ____ No

Has child ever been held back in school? ____ Yes ____ No If Yes, describe when:

_____

How does the child feel about school? Which is the child's favorite part of school?

_____

What grades does the child usually receive in school? Describe if there have been any recent changes in the child's academic performance and note when such changes occurred.

_____

_____

Has the child been tested psychologically? ____Yes ___No If Yes, describe for what and when and name of testing psychologist: _____

_____

_____

Approach to School Work:

___ Organized ___ Industrious ___ Responsible ___ Interested

___ Self-directed___ No initiative ___ Refuses ___ Does only what is expected

___ Sloppy ___ Disorganized___ Cooperative ___ Doesn't complete assignments

___ Other (describe): _____

Performance in School (Parent's Opinion):

___ Satisfactory ___ Underachiever ___ Overachiever

___ Other (describe): _____

Child's Peer Relationships:

___ Spontaneous ___ Follower ____ Leader ___ Difficulty making friends

___ Makes friends easily ___Long-time friends ___Shares easily

___ Other (describe): _____

Leisure/Recreational Habits

Describe the child's areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.) _____

_____

_____

Who can Stephanie Richards, LPC, PLLC thank for referring you? (check which apply)

□ Referred by a Client □ Professional Referral □ Website □ Other:

Please specify the name and contact of the referral source that you checked:

_____

_____

Please turn in this form to your child's counselor at the initial session.

SECTION II. TO BE COMPLETED BY THE BIO/ADOPTIVE MOTHER OF CHILD

Child's Mother's Information Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Phone: _____ Email: _____

Occupation: _____ Mother's highest education: _____

Does the child mostly reside with the mother? ___ Yes ___ No ___ Shared equally

What is your relationship to the child? ___ Natural parent ___ Step-parent ___ Adoptive parent ___ Foster home Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the other parent? _____ Yes _____No If Yes, please explain: _____

_____

How is the child disciplined by the mother and for what reasons?

_____

_____

How would you rate the consistency of this discipline? (0-10, 0=no consistency and 10=always consistent) _____

Quality of Relationship with Siblings/Others Who Live in the Mother's Household:

Names of Siblings	Age	Gender	Lives with the child	Quality of relationship with sibling
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good

Others living in the household	Age	Gender	Relationship (e.g., cousin, foster child)	Quality of relationship with sibling
_____	____	__ F __ M	_____	__ poor __ average __ good
_____	____	__ F __ M	_____	__ poor __ average __ good
_____	____	__ F __ M	_____	__ poor __ average __ good

What would the mother of the child like to see addressed in counseling?

_____

_____

List any current concerns the mother has about the child: _____

_____

Please turn in this section to counselor in person or fax email to Counselor@StephanieRichardsLPC.com

SECTION II. TO BE COMPLETED BY THE BIO/ADOPTIVE FATHER OF CHILD

Child's Father's Information

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Phone: _____ Email: _____

Occupation: _____ Father's highest education: _____

Does the child mostly reside with the father? ___ Yes ___ No ___ Shared equally

What is your relationship to the child? ___ Natural parent ___ Step-parent ___ Adoptive parent ___ Foster home Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the other parent? _____ Yes _____No If Yes, please explain: _____

_____

How is the child disciplined by the father and for what reasons?

_____

_____

How would you rate the consistency of this discipline? (0-10, 0=no consistency and 10=always consistent) _____

Quality of Relationship with Siblings/Others Who Live in the Father's Household:

Names of Siblings	Age	Gender	Lives with the child	Quality of relationship with sibling
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good
_____	____	__ F __ M	__ home __ away	__ poor __ average __ good

Others living in the household			Relationship (e.g., cousin, foster child)	Quality of relationship with sibling
_____	____	__ F __ M	_____	__ poor __ average __ good
_____	____	__ F __ M	_____	__ poor __ average __ good
_____	____	__ F __ M	_____	__ poor __ average __ good

What would the father of the child like to see addressed in counseling?

_____

_____

List any current concerns the father has about the child: _____

_____

Please turn in this section to counselor in person or fax email to Counselor@StephanieRichardsLPC.com