

Thrive Psychological and Consulting Services, LLC
Comprehensive Evaluations for Children and Adolescents

DEVELOPMENTAL HISTORY

Identification

Child's name: _____ Birthdate: _____ Age: _____ Grade: _____

Person completing form: _____ Today's Date: _____

Relation to child: _____

Please describe your current concerns about your child:

How long have you had these concerns? _____

Please list the names and relations of people who currently live with the child: (Please put age for siblings.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Mother's name: _____ **Best Phone:** _____

Address: _____ **City:** _____ **Zip:** _____

Currently Employed: Yes No **Occupation:** _____ **Email:** _____

Maternal family history of learning or mental health concerns: _____

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Father's name: _____ Best Phone: _____

Address: _____ City: _____ Zip: _____

Currently Employed: ___ Yes ___ No Occupation: _____ Email: _____

Paternal family history of learning or mental health concerns: _____

Parents are currently: (circle) Married Divorced Remarried Never Married Other: _____

Child's legal custodian/guardian is: _____

Development

Pregnancy and Delivery

Any prenatal problems: _____

Was the child premature? _____ If so, born at _____ weeks Weight at birth: _____

Any birth complications? _____

Please list any problems during infancy

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Did child reach milestones on time? ____ If not, please list delays and at what age met milestones (i.e., sitting, crawling, walking, speech/language)

Health

List all childhood illnesses and age of onset (i.e., chronic ear infections, hospitalizations, medications, allergies, head trauma, accidents and injuries, surgeries, seizures, etc.)

Current medications: _____

Past medications: _____

Any difficulties with sleep? _____

Any problems with eating/appetite? _____

Name of child's pediatrician/primary care doctor: _____

Behavior

Please list any concerns you have about your child's behavior:

How does your child get along with peers?

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How does your child get along with siblings?

Are there any stressful events occurring in the family that may be affecting your child?

To your knowledge, has your child ever been abused or neglected?

Has your child ever been evaluated before?

Education

Please list all schools child has attended Grade Age Concerns

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Grades repeated: _____

Does your child currently have an IEP or 504 Plan? _____

If yes, what eligibility area? (i.e., Learning Disability, Autism, Other Health Impairment, etc.)

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Has your child ever had an IEP or 504 Plan in the past? _____

Does your child receive any tutoring? _____

Does (did) your child have any problems learning letters/numbers? _____

Can (did) your child struggle to rhyme words? _____

Does your child confuse sounds in words when speaking? (i.e., aminal for animal) _____

Please list your child's interests, toy preferences, and any special talents.
