Client Number: _____

FAIRVIEW COUNSELING
DEVELOPMENTAL FORM

Person(s) completing this form: _____ Today's date: _____

Child's name: _____ Birth date: _____ Age: _____

Mother's name: _____ Birth date: _____ Home phone: _____

Father's name: _____ Birth date: _____ Home phone: _____

Parents are currently: Married Divorced Remarried Never married Other: _____

Child's custodian/guardian is: _____

Stepparent's name: _____Birth date_____ Home phone: _____

Please fill in any information you have on the areas listed below:

Pregnancy and Delivery

Was this pregnancy planned? Yes No

Prenatal medical illnesses and health care:

_____

_____

_____

Did the mother or father use drugs or alcohol during the pregnancy? Yes No

Was the child premature? _____ Weight and height at birth: _____

Apgar score (1-10) _____

Any birth complications or problems?

_____

_____

The First Few Months of Life

Breast-fed? _____ if so, for how long? _____

Did the child have any of the following?

- ❑ Colic
- ❑ Excessive crying

- ❑ Excessive vomiting
- ❑ Ear or hearing problems/infections
- ❑ Feeding problems
- ❑ Other _____

Sleep patterns or problems:

_____

_____

_____

Describe the child's personality:

_____

_____

_____

Milestones

At what age did this child do each of these?

Sat without support: _____

Crawled:_____

Walked without holding on: _____

Helped when being dressed: _____

Ate with a fork:_____

Stayed dry all day:_____

Didn't soil his/her pants: _____

Stayed dry all night: _____

Dressed self completely: _____

Speech/Language Development

Age when child said first word understandable to strangers: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? Yes No

Was the mother depressed after the baby's birth? Yes No

Did the child, a sibling or parent have an operation or was hospitalized since the birth?

Explain:

_____

_____

_____

_____

How old was the baby when the parents returned to work? _____

Who took care of the baby while the parents worked?

_____

_____

_____

_____

_____

Health

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?

List all medications and supplements that the child is currently taking:

_____

_____

Residences

How many homes has this child had and at what age did the moves occur?

_____

_____

_____

Residential placements, institutional placements, or foster care

_____

_____

_____

Schools

School (Name, district, address, phone)	Grade	Teacher

May I call and discuss your child with the current teacher? Yes No

Initial _____

Does your child have any difficulties at school?

(Explain)_____

_____

_____

_____

_____

Has your child been diagnosed with a learning disability? Yes No

List any special programs that your child has been involved with at school:

_____

_____

_____

Special Skills or Talents of Child

List hobbies, sports; recreational, TV, and toy preferences; etc.:

_____

_____

_____

Describe a typical day in your child's life:

_____

_____

_____

_____

Please list your child's friends:

_____

_____

_____

Has you child or a close family member experienced any of the following:

- ❑ Death of family members, friends, or pets.
- ❑ Victim of a violent crime
- ❑ Domestic violence
- ❑ Rape
- ❑ Motor vehicle accidents
- ❑ Marital separation
- ❑ Divorce
- ❑ Mental illness such as schizophrenia, manic depression, ect.
- ❑ Serious physical illness or disability
- ❑ Dog/ animal bites
- ❑ Other

Habits

Check all that are a problem.

- ❑ Temper tantrums/ aggression

- ❑ Frustration tolerance
- ❑ Accident prone
- ❑ Attention span
- ❑ Memory
- ❑ Fears
- ❑ Anxiety
- ❑ Interrupts adults
- ❑ Disobeys
- ❑ Clumsy
- ❑ Awareness of danger/ safety issues
- ❑ Stealing
- ❑ Fighting
- ❑ Self-esteem
- ❑ Eating
- ❑ Sleeping
- ❑ Fine motor problems (picking up small objects)
- ❑ Gross motor (running, jumping)
- ❑ Language (lisp, stuttering,)

Is they're anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____

_____

_____

_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.