

Client # \_\_\_\_\_

FairView Counseling & The Play Therapy Center  
Developmental Form

Person(s) completing this form: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Phone: \_\_\_\_\_

Parents are currently: Married Divorced Remarried Never Married Other: \_\_\_\_\_

Child's custodian/guardian is: \_\_\_\_\_

Stepparent's name: \_\_\_\_\_ Birth date: \_\_\_\_\_ 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 a stranger: \_\_\_\_\_

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?

If yes, please 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
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_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Does your child have any difficulties at school? Yes No

If Yes, Please 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: \_\_\_\_\_

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Please list your child's friends: \_\_\_\_\_

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Has your 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 depressions, etc.
- 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 there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

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

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