BOYS TOWN

Behavioral Health Clinic
Developmental History

Name of Client: _____ Date of Birth _____

Developmental History

Was the birth at full term? Yes ☐ No ☐

If no, how many weeks of gestation? _____ weeks

Birth weight: _____ pounds _____ ounces

Was there a C-section? Yes ☐ No ☐ If yes, was it planned? Yes ☐ No ☐

Did your child spend time in the NICU? Yes ☐ No ☐ If yes, how long? _____

Complications? _____

Was there smoking/alcohol/substance use during pregnancy? Yes ☐ No ☐

If yes, list: _____

Did your child demonstrate excessive crying or colic? Yes ☐ No ☐

Were there feeding or eating difficulties? Yes ☐ No ☐ Are they current? Yes ☐ No ☐

Were there sleeping difficulties? Yes ☐ No ☐ Are they current? Yes ☐ No ☐

What time does child currently fall asleep: _____ Wake up time? _____

Is the bedtime routine a struggle? Yes ☐ No ☐

Does your child wake up frequently during the night? Yes ☐ No ☐

Does your child wet the bed more than once per week? Yes ☐ No ☐

Developmental Milestones

Speech: On time ☐ Delayed ☐ By how long? _____

Walking: On time ☐ Delayed ☐ By how long? _____

Toilet training: On time ☐ Delayed ☐ When was it achieved? _____

Has your child attended Speech therapy? Yes ☐ No ☐ When? _____

Has your child attended Occupational therapy? Yes ☐ No ☐ When? _____

Behavior

What percent of the time does your child follow directions the first time they are given?

At home: _____ % At school: _____ %

Comments: _____

How is misbehavior managed? _____

Is it effective? Yes ☐ No ☐

Friendships

Describe your child's relationships with peers/friends: _____

School

Typical grades for your child: _____

Favorite subject? _____ Least Favorite Subject? _____

Has your child repeated a grade? Yes ☐ No ☐ If yes, what grade? _____

Has your child been suspended? Yes ☐ No ☐ If yes, how many times? _____

Has your child been expelled? Yes ☐ No ☐ If yes, what grade(s)? _____