

CHILD DEVELOPMENTAL HISTORY

Name: _____ Date: _____

What is the main problem that led to the child being brought here?

- Child had no problems Problems thinking clearly Refusal to go to School Neglect by Parents
- Depression Arguments with Parents Behavior Problems at Home Bed-Wetting
- Anxiety Adjustment to Parents Divorce Health Problems Stealing
- Suicidal Thoughts Academic Problems Physical Abuse Fears
- Suicidal Actions Behavior Problems in School Sexual Abuse Other: _____

How severe is this problem?

- Does not apply Mild Moderate Severe

How long has the child had this problem?

- Does not apply For the past several days For the past year For the past several years
- For the past several years For past several months For the past two years Other: _____

Which of the following has this problem affected?

- Does not apply The child's relationships with family members The child's behavior
- None The child's physical health Other: _____
- The child's academia performance The child's emotional health
- The child's relationship with peers

What is the child's status in school?

- Has not started school Part-time, regular classes Expelled from school
- Full-time, regular classes Part-time, special education classes Being Tutored at Home
- Full-time, special education classes Suspended from school Other: _____

What grade is the child in now (or when school starts again in the fall)?

- Not in school, will not be in school Preschool First Third Fifth Seventh
- Kindergarten Second Fourth Sixth Other: _____

Who does the child live with?

- Natural parents Shared living arrangements with both parents (divorce) Foster parents
- Natural Mother Relatives Lives in an orphanage
- Natural Father Friends Lives in an agency
- Natural Mother and Stepfather Adoptive Parents Other: _____
- Natural Father and Stepmother

Where does the child live?

- House Trailer Boarding School Institution
- Apartment Condo Agency housing Other: _____

How many children are in the child's family including the child?

- Only child 2 3 4 5 6 7 8 9 10 More than 10

How old was the child's natural father at the time of the child's birth?

- Do not know 15-19 20-29 30-39 40-49 50 or older

Doctor's Notes: _____

Doctor's Initials: _____

How old was the child's natural mother at the time of the child's birth?

- Do not know 15-19 20-29 30-39 40-49 50 or older

Was the pregnancy planned?

- Do not know Yes No

What was the mother's attitude while pregnant with the child?

- Do not know Ambivalent Angry Worried Moody
 Accepting Happy Depressed Fearful Other: _____

What level of stress would you say the mother experienced during her pregnancy?

- Do not know Mild Moderate Severe

Did the mother have any illnesses during her pregnancy?

- No Yes. Explain: _____

What was the child's physical condition immediately after birth?

- Do not know Problems with heart Jaundice Other: _____
 Normal, no unusual Problems with bones Had blood transfusion _____
problems Low birth weight Had seizures _____
 Injured at birth Problems with digestion Fever Place in intensive care
 Difficult breathing Infection Placed in incubator

Did the child receive all required vaccinations ("shots")?

- No Vaccinations All required shots Only some selected vaccinations. Explain: _____

Approximately how much did the child weigh when born?

- Do not know 1 pound 2 pounds 3 pounds 4 pounds 5 pounds 6 pounds
 7 pounds 8 pounds 9 pounds 10 pounds 10 + pounds

How many days did the child spend in the hospital after birth?

- Do not know More than 5 days More than 20 days
 5 days or less More than 10 days More than 30 days

Who was the child's primary caretaker before age 2?

- Natural Parents Adoptive Natural Father Grandmother Orphanage
 Natural Mother Parents and Stepmother Grandfather Agency
 Natural Father Natural Mother Grandparents Foster Parents Other: _____
and Stepfather

How was the child fed before age 2?

- Do not know Bottle Breast Bottle and Breast

Describe the child's temperament before age 2?

- Do not know Withdrawn Affectionate Hypersensitive Fearful Other: _____
 Calm Happy Crying Angry Cranky _____
 Active Unhappy Difficult Regular Curious _____
 Sociable Sleepy Irritable Irregular Playful _____

Doctor's Notes: _____

Doctor's Initials: _____

Schmoe Chiropractic Clinic LLC

When did the child develop the ability to sit?

- Do not know 6 months 1 to 1 ½ years Other: _____
 Before 6 months 6 months to 1 year 1 ½ to 2 years

When did the child develop the ability to crawl?

- Do not know 6 months 1 to 1 ½ years Other: _____
 Before 6 months 6 months to 1 year 1 ½ to 2 years

When did the child learn to walk?

- Do not know Before 1 year 1 to 1 ½ years 1 ½ to 2 years After 2 years Other:

When did the child learn to talk?

- Do not know Before 1 year 1 to 1 ½ years 1 ½ to 2 years After 2 years Other:

When did toilet training begin?

- Do not know 2 years 2 ½ years After 4 years
 Before 1 year 3 years 3 ½ years Other: _____
 1 year 1 ½ years 4 years

Were there problems in toilet training?

- No Mild Moderate Severe problems Do not know

Has the child suffered any major illnesses or conditions?

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Tonsil infections | <input type="checkbox"/> Scabies | <input type="checkbox"/> Insect bites |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fetal alcohol syndrome | <input type="checkbox"/> Hernias | <input type="checkbox"/> Hip dysplasia | <input type="checkbox"/> Measles, Mumps, |
| <input type="checkbox"/> Eczema, psoriasis,
seborrhea, dermatitis | <input type="checkbox"/> Heart/Vascular disorders | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Hives (urticaria) | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Colic | <input type="checkbox"/> Rickets |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Tumors/cancer | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Strabismus | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Diphtheria | | |

Has the child suffered any physical traumas (falls, car accidents, sports injuries, etc)?

- No Yes. Explain: _____

Who was the child's primary caretaker from ages 2-5?

- Natural Parents Natural Father and Stepmother Agency
 Natural Mother Natural Father Grandparents Other: _____
 Adoptive Parents Grandmother Grandfather Foster Parents _____
 Natural Mother and Stepfather Orphanage

Describe the child's motor development (running, jumping, throwing, etc) from ages 2-5.

- Do not know Average in comparison to other children Other: _____
 Advanced in comparison to other children Slow in comparison to other children _____

Describe the child's language development (talking in sentences, vocabulary, etc) from ages 2-5.

- Do not know

Doctor's Notes: _____

Doctor's Initials: _____

- Advanced in comparison to other children Average in comparison to other children Other: _____
 Slow in comparison to other children

Describe the child’s social development (development of friendships, relationships with peers, relationships with adults, etc.) from ages 2 – 5.

- Do not know Average in comparison to other children Slow in comparison to other children
 Advanced in comparison to other children Other: _____

Describe the child’s mental development (counting, knowledge of alphabet, doing puzzles, understanding concepts, etc.) from ages 2 – 5.

- Do not know Average in comparison to other children Slow in comparison to other children
 Advanced in comparison to other children Other: _____

Describe the child’s temperament from ages 2 – 5.

- Do not know Withdrawn Sleepy Irritable Irregular Playful
 Calm Happy Affectionate Hypersensitive Fearful Other: _____
 Active Unhappy Crying Angry Cranky
 Sociable Alert Difficult Regular Curious

Describe the child’s current subject strengths in school.

- Does not apply Art Music Reading Math Spelling English Science
 None History Social Studies Other: _____

Describe the child’s current subject weaknesses in school.

- Does not apply Art Music Reading Math Spelling English Science
 None History Social Studies Other: _____

Describe the child’s current skill strengths in school.

- Does not apply Handwriting Understanding concepts Reading comprehension
 None Memorizing Pleasing the teacher Spelling
 Concentration Playing attention in class Behaving correctly Working hard
 Organization Getting assignments done on time Taking tests Intelligence
 Test preparation Being careful and checking work Reading speed Other: _____
 Paper and Reports Vocabulary and expression

Does the child currently have problems with attention and concentration in the classroom?

- Does not apply Not getting assignments done Forgets teacher’s instructions Difficulty being quiet
 No Material disorganized or messy Acts without deliberation Other: _____
 Daydreaming Difficulty sitting still

Describe the child’s current skill weaknesses in school.

- Does not apply Memorizing Vocabulary and expression Reading speed
 None Playing attention in class Reading comprehension
 Concentration Getting assignments done on time Understanding concepts Spelling
 Organization Pleasing the teacher Working hard
 Test preparation Being careful and checking work Behaving correctly Intelligence
 Paper and Reports Taking tests Other: _____

Does the child currently have behavior problems in the classroom?

Doctor’s Notes: _____

Schmoe Chiropractic Clinic LLC

- Does not apply Required to sit in an isolated area Has been sent to the principal's office Can't wait until turn
- No Often reprimanded Talks out of turn _____

How is the child described by current teacher(s)?

- Does not apply Distractible Has problem maintaining attention Interrupts
- None of the following Doesn't wait turn in games Switches from one unfinished task to another Doesn't listen
- Fidgety Answers questions before completed Has problem playing quietly Frequently loses objects
- Has problem remaining seated Fails to finish assignments Talks excessively Fails to consider safety
- Other: _____

Which of the following are true?

- Do not know Child has had regular medical checkups Child has had regular vision tests Child has had regular dental checkups
- None Child has had regular hearing tests

Which of the following are true?

- None Child wears a hearing aid Child wears orthopedic/corrective shoes Child uses crutches for walking
- Child wears glasses Child wears an orthopedic brace Other: _____

What problems does the child have with sleep?

- None Trouble getting to sleep Restlessness in bed Falling asleep in school Sleepwalking
- Waking up a lot at night Waking up too early in the morning Refusing to go to bed at night Nightmares or Night Tremors
- Not getting enough sleep Sleeping enough, but still tired Refusing to get up in the morning Other: _____
- Sleeping too much

What problems does the child have with eating?

- None Eating too many snacks Has a poor appetite Other: _____
- Refuse to eat balanced diet Finicky about food Overeats

Does the child have problems with wetting or soiling?

- No Frequently wets bed Occasionally wets pants Occasionally soils pants
- Occasionally wets bed Frequently soils bed Frequently wets pants Other: _____

What kinds of discipline do the child's parents (or caretakers) use?

- Does not apply None Lectures Punishment Loss of allowance
- Do not know Yelling Physical Grounding Withdrawal of privileges

How strict are the child's parents (or caretakers)?

- Does not apply Very strict Average Very permissive
- Do not know Strict Permissive

Has the child ever been abused by a current or previous member of the household?

- Does not apply No Yes, emotionally Yes, sexually
- Do not know Yes, physically Yes, verbally Yes, neglected

Which of the following describes the child now?

- Has many close friends Has several close friends Has few close friends Has no close friend

Doctor's Notes: _____

Doctor's Initials: _____

*Thank you for carefully
answering each question!*

*Patient: Black Ink,
Doctor: Red ink*

Schmoe Chiropractic Clinic LLC

Any comments or other concerns you wish to express?

Doctor's Notes: _____

Doctor's Initials: _____