



Heather Fabbre LMFT

Licensed Marriage Family Therapist
Registered Art Therapist

Client Information & Developmental History

Date: _____

Child's name: _____ Age: _____ DOB: _____ School:

Grade: _____ Teacher: _____ Race/Ethnicity
identity: _____ Handedness? Right Left

Person providing information:

Respondent's name and relationship to child: _____

Home phone: _____ Work phone: _____

Best day/time to reach you? _____ At what phone # _____

Referral information:

Briefly describe your reason(s) for seeking help at this time? _____

Who referred you for this service? _____

Parent information:

Mother's name: _____ Stepmother? No Yes

Address: _____

Contact phone number: _____ Occupation: _____

Employer: _____ How long with present employer: _____

Highest grade completed: _____

Father's name: _____ Stepfather? No Yes

Address: _____

Contact phone number: _____ Occupation: _____

Employer: _____ How long with present employer: _____

Highest grade completed: _____

Does the child have other parent(s)/stepparent(s)? No Yes If yes,
name(s): _____ relationship _____ phone numbers: _____

Development

Circle any problems this child has experienced and describe on lines provided below

Walking Unclear speech Feeding Underweight problems Overweight problems
Colic Sleep problems Eating disorder Difficulties learning to ride a bike, skip, throw, catch



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Has the child had any of the following problems during the first 4 years of life?

Eating, motor skills, sleeping too much, temper tantrums, sleeping too little, failure to thrive, separating from parents, excessive crying Describe: _____

Medical History

Childhood illness/injuries such as: Measles, German measles, mumps, chicken pox, tuberculosis, whooping cough, scarlet fever, head injury (Coma or loss of consciousness), sustained high fever, Rheumatic fever, Diphtheria, Meningitis, Encephalitis, Anemia, Fever above 104, other serious illness or operations: Describe _____

Has this child been on long-term medications (more than 6 months)? Yes No

If yes, when and what kind _____

Please circle if child has/had any of these medical problems:

Respiratory: frequent cold, chronic cough, asthma, hay fever, sinus condition

Cardiovascular: shortness of breath or dizziness with physical exertion, activity limitations due to heart condition, heart murmur

Gastrointestinal: excessive vomiting, frequent diarrhea, constipation, stomach pain

Genitourinary: urination in pant/bed, pain while urinating, excessive urination, strong urine odor

Musculoskeletal: muscle pain (describe), clumsy walk, poor posture, other muscle problem

Skin: frequent rashes, bruises easily, sores (describe) severe acne, itchy skin, eczema, etc

Neurological: seizures/convulsions, speech deficits, accident prone, bites nails, sucks thumb, grinds teeth, has tics/twitches, bangs head, rocks back and forth, bowel movements in pants/bed, taken meds to increase activity, taken tranquilizing medication

Allergies: allergic to medicine, food, other

Hearing: ear infections, hearing problems, ear tubes Most recent hearing exam? _____

Vision: vision problems, wears glasses/contacts Most recent eye exam? _____

Please describe above circled issues here (e.g., when, how long, where in body, if treated, any complications, etc.) _____



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Have any of the child's family members had any of the following? If yes, please specify family member's relationship to this child.

Cancer _____ Tourette's syndrome _____
Heart disease _____ Food allergies _____ Learning disability _____
Seizures or epilepsy _____ Speech or language problem _____ Mental retardation _____
Alcohol/drug abuse _____ Nervousness _____ Mental illness (specify) _____
Physical handicap _____ Behavior disorder _____
Alzheimer's disease _____ Emotional disturbance _____ Other: describe _____

Child's primary care physician _____ Phone _____

Address _____

How often does this child see the doctor? _____ Date of last visit? _____

Is the child currently on medication? Yes No

If yes, indicate type and reason _____

Has this child ever had psychological counseling or therapy? Yes No If yes, where, with whom and how long _____

Why did the child stop? _____

Does child have history of alcohol/substance abuse? If yes, explain _____

Has the child ever had a neurological exam Yes No If yes, neurologist's name _____ Reason

for exam? _____ Has the child ever had a psychological or psychiatric

evaluation? Yes No Do you have a copy of the results? Yes No

Family history:

Is this child closer to one parent (caregiver) than another? No Yes If yes, which? _____

Has this child ever experienced any parental separations, divorces, or death? No Yes
If yes, when? _____ How old was the child at the time _____ Please describe the
circumstances _____

If parents are separated or divorced, who has custody of this child? _____

How often does the other parent see this child? Weekly or more often Once a month
 Few times a year Never

How often does the child see grandparents? Weekly or more often
 Once or twice a month Few times a year Never No grandparents living



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Home environment:

Please list all living arrangements this child has had (e.g., parents only, foster, kinship-care, residential treatment, group home, etc.) with approximate time child lived in each:

Primary Caregivers:

Please provide the following information about the primary caregivers, if not given previously.

Name: _____ Relationship to child _____

Address: _____

Contact phone number(s): _____ Occupation: _____

Employer: _____ How long with employer: _____ Highest Grade? _____

With whom does this child currently live? (list all names, ages, & relationship) _____

How long in current living situation? _____

How does this child get along with each person in the home? _____

Apartment Single home other _____ How long at current address? _____

Check the activities in which this child often participates with the family

Conversations Movies Television Church Games Meals Sport Trips Visits with relatives Homework help Other _____

If church, what religion and how involved is the family? _____

If primary caregiver works outside the home, please provide the following information

Who cares for this child when caregivers are gone? _____

How many hours per day is this child in a child-care setting? _____ How many different

people care for this child (please explain) _____

What do you enjoy most about this child? _____

What do you find most difficult about raising this child? _____



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Who is mainly in charge of discipline in the home? _____ Do all caregivers agree on discipline? _____ Describe discipline techniques _____

Friendships: *Please indicate how this child relates to other children*

Has problems relating to or playing with other children No Yes If yes, describe:

Fights with playmates No Yes _____

Prefers playing w/ younger children No Yes _____

Has difficulty making friends No Yes _____

Prefers to play alone No Yes _____

Are there children in the neighborhood with whom this child could play No Yes

What role does this child take in peer group games (e.g., leader, aggressor, etc.)? _____

Recreation/Interest: *What activities does this child enjoy?*

Sports: _____

Hobbies: _____

Other: _____

Has this child's interest in participating in these activities declined recently? No Yes

Behavior/Temperament: *Please indicate whether this child exhibits any of the following*

Is easily overstimulated in play No Yes Seems unhappy most of the time No Yes

Has a short attention span No Yes Withholds affection No Yes

Seems impulsive No Yes Hides feelings No Yes

Seems overly energetic in play No Yes Requires a lot of parent attention No Yes

Lacks self-control No Yes Overreact when faced with prob. No Yes

Uncomfortable meeting new people No Yes Has abnormal fears (describe) No Yes

What "sets this child off"? _____

What tends to work best to control behaviors/emotions? _____



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Adaptive Skills: *Indicate whether this child has the following skills*

Dresses self	No	Yes	Bathes self	No	Yes
Buys gifts or presents for others	No	Yes	Helps with chores	No	Yes
Can get help or find home if lost	No	Yes	Has good table manners	No	Yes
Says "please" and "thank you"	No	Yes	Tells time accurately	No	Yes
Does this child get an allowance?	No	Yes	If yes, how is it spent? _____		

Educational History:

Preschool

Does or did the child attend preschool? No Yes At what age? _____
Amount of time per day _____ Days per week _____
Any problems in preschool? No Yes If yes, describe _____

Does or did the child attend kindergarten? No Yes
Any problems in kindergarten No Yes If yes, describe _____

Elementary/High School

Has child changed schools for reasons other than normal academic progression? No Yes
If yes, when and why? _____

Has been retained in a grade in school No Yes If yes when and why? _____

Has skipped a grade in school No Yes If yes when and why? _____

Has difficulty with reading No Yes If yes, describe? _____

Has difficulty with math No Yes If yes, describe? _____

Gets poor grades No Yes Describe most recent report card results (highest & lowest grade on report card) _____

Has child been tested for special education? No Yes If yes, when _____

Currently placed in special education? No Yes
If yes, what type of class? _____ Hours per day _____

Has anyone in the child's family ever been in special education? No Yes
If yes, who? _____ What type of class? _____

Dislikes going to school? No Yes



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Is or has been absent from school frequently No Yes If yes, when and why?

If in high school, when will this child graduate? _____

Do you have any concerns about the quality of this child's school or teachers? No Yes

If yes, describe _____

Has child ever had difficulty with the police? No Yes If yes, explain (reason, age, probation, probation officer) _____

Chief complaint:

- | | | |
|---|---|---|
| <input type="checkbox"/> Very unhappy | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Temper outbursts | <input type="checkbox"/> Disobedient | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Infantile | <input type="checkbox"/> Sexual trouble |
| <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Mean to others | <input type="checkbox"/> School performance |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Destructive | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Trouble with the law | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Running away | <input type="checkbox"/> Soiled pants |
| <input type="checkbox"/> Slow | <input type="checkbox"/> Self-mutilating | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Rocking | <input type="checkbox"/> Sickly |
| <input type="checkbox"/> Lacks initiative | <input type="checkbox"/> Shy | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Undependable | <input type="checkbox"/> Strange behavior | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Peer conflict | <input type="checkbox"/> Strange thoughts | <input type="checkbox"/> Suicide talk |
| <input type="checkbox"/> Phobic | | |

How long these problems occurred _____

Additional comments _____
