HOUSE of HOPE
KANSAS CITY
Healing Teens • Restoring Families • Transforming Communities

Child Developmental History

Child's Name: _____ **Date of Birth:** _____

Age: _____

Family Information

Home Address: _____ **City/State/Zip Code:** _____

Father's Name: _____ **Mother's Name:** _____

Sibling's Name: _____ **Age:** _____ **Sibling's Name:** _____ **Age:** _____

Sibling's Name: _____ **Age:** _____ **Sibling's Name:** _____ **Age:** _____

Who else lives in the home? (please include name & relationship to child): _____

Are there any close family members not living in the home? Y N Who? _____

Adopted Y N If so, at what age? _____

Explain who the child has lived with since birth? _____

Behavioral Concerns

What concerns or issues convinced you to seek assistance now? _____

_____

HOME behavioral concerns: _____

SCHOOL behavioral concerns: _____

When did you start noticing these behavioral concerns? _____

Current or past stressors that may be contributing to my child's problems: _____

_____

Mental health diagnosis and when they are diagnosed: _____

_____

Is there a history of, or current concern with any of the following? If so, how long have these been problems?

_____ School behavioral problems	_____Academic/special education	_____Eating Problems
_____ Stealing	_____ Speech difficulties	_____ Masturbation
_____ High temperatures	_____ Runaway	_____ Head injuries/concussions

_____ Temper tantrums	_____ Poor memory	_____ Crying spells
_____ Wetting pants	_____ Cruel to animals	_____ Soiling pants
_____ Coordination	_____ Lying	_____ Truancy
_____ Avoids cuddling	_____ Impulsivity	_____ Headaches
_____ Poor attention	_____ High energy	_____ Bed wetting
_____ Constipation	_____ Fire setting	_____ Sex play with other children
_____ Frequent bad dreams	_____ Aggressive behavior	_____ Defiance to authority
_____ Legal problems	_____ Obsessive behavior	_____ Suicidal thoughts
_____ Fears	_____ Attention Deficit Disorder	_____ Hallucinations
_____ Bizarre Behaviors	_____ Other:_____	

How does your child get along with other children at home and/or school? _____

_____

What are your concerns about your child's friends? _____

_____

Describe relationship between your child and the following people:

Mother: _____ Father: _____

Siblings: _____

What are your child's strengths? _____

Treatment (current and previous)

INDIVIDUAL Therapy Y N Dates: _____ With Who? _____

Results: _____

Individual Therapy Y N Dates: _____ With Who? _____

Results: _____

Individual Therapy Y N Dates: _____ With Who? _____

Results: _____

FAMILY Therapy Y N Dates: _____ With Who? _____

Results: _____

FAMILY Therapy Y N Dates: _____ With Who? _____

Results: _____

Intensive Outpatient Programs (IOP) Y N Dates: _____ Where? _____

Results: _____

Partial Hospitalization Program (PHP) Y N Dates: _____ Where? _____

Results: _____

Inpatient Y N Dates: _____ Where? _____

Reason: _____ Results: _____

Inpatient Y N Dates: _____ Where? _____

Reason: _____ Results: _____

FAMILY HISTORY

Is there a family history of mental illness in your family? Y N
Please specify if yes: _____

_____

Is there a family history of substance abuse in your family? Y N
Please specify if yes: _____

_____

Pregnancy History – Mother

While pregnant with this child was the mother under a doctor's care? Y N

Mother's health during pregnancy: _____ Good _____ Fair _____ Poor If fair or poor explain why: _____

_____

During pregnancy, did the mother:

Take any medications? Y N Please list: _____
Drink alcohol? Y N How much? _____
Smoke? Y N How much? _____
Drug Use? Y N What/How much? _____

During the pregnancy where there any complications? _____

Length of pregnancy: _____ Delivery was (check one) ____ normal ____ breach ____ Cesarean
Birth weight: _____ Problems after delivery? _____
Bottle-fed: _____ Breast-fed: _____ Age weaned: _____

DEVELOPMENTAL HISTORY

As well as you can remember, where there any delays in the follow areas?

	Y	N		Y	N
Sat alone			**Toilet trained**		
Named colors			**Crawled**		
Rode bike			**Said alphabet**		
Stood along			**Used sentences**		
Began to read			**Walked Along**		
Buttoned clothes			**Tied shoes**		
Said Words					

Any speech/language problems? _____

Any problems with toilet training? _____
Dry at what age? _____ Bowled trained at what age? _____

Age helped with dressing? _____ Age dressed alone? _____ Fed self at what age? _____
Right or left handed? _____ Good with hands? _____ Well coordinated? _____
Good gross motor skills? _____ Good fine motor skills? _____ Clumsy? _____

Any sleep problems? _____

Is there a history of the following? If so, what age?

_____ Blank spells _____ Falling spells _____ Fainting spells
_____ Impulsive behavior _____Unusual fears _____ Rocking behavior
_____ Head bumping _____ Temper tantrums _____ Daredevil behavior

MEDICAL HISTORY

Please list any CURRENT or PAST medical or neurological problems: _____

_____

Hospitalization Y N Dates: _____ Reason: _____
Dates: _____ Reason: _____

Primary Care Doctor: _____ Last Physical: _____

Child Height: _____ Weight: _____ Allergies: _____

Medications Name:_____ How long has your child been on it? _____
Dosage: _____ Reason: _____ Results: _____

Name:_____ How long has your child been on it? _____
Dosage: _____ Reason: _____ Results: _____

Name:_____ **How long has your child been on it?** _____
Dosage: _____ **Reason:** _____ **Results:** _____

Name:_____ **How long has your child been on it?** _____
Dosage: _____ **Reason:** _____ **Results:** _____

Name of doctor/psychiatrist who prescribed medications: _____

Substance Use	**Tobacco**	**Y**	**N**	**Alcohol**	**Y**	**N**
(please indicate	**Vaping**	**Y**	**N**	**Marijuana**	**Y**	**N**
if currently using)	**Other Drugs**	**Y**	**N**	**Prescription Pills**	**Y**	**N**

History of Abuse	**Emotional**	**Y**	**N**	**Physical**	**Y**	**N**
	Sexual	**Y**	**N**			

If so, explain including dates: _____

History of Trauma	**Close Death**	**Y**	**N**	**Move**	**Y**	**N**		
	Natural Disaster	**Y**	**N**	**Accident**	**Y**	**N**		
	Divorce	**Y**	**N**	**Crime**	**Y**	**N**		
	Other: _____							

Suicidal / Self Harm	**Suicidal Thoughts**	**current**	**Y**	**N**	**past**	**Y**	**N**		
	Suicide Attempt	**Y**	**N**	**When?** _____		**Plan:** _____			
				When? _____		**Plan:** _____			
	Self Harm	**current**	**Y**	**N**	**past**	**Y**	**N**		

Method: _____

Frequency: _____

EDUCATION

Current Grade Level _____ **Current Reading Level** _____ **At grade level? If not, why?** _____

_____

Does your child have an IEP? If so, describe accommodations. _____

How does your child do with an online school platform? _____

Please describe average grades / school performance (circle one): **Does Well/Mostly A's and B's**
Does Okay/ B's and C's **Does Fair/ Solid C's** **Does Poor/ Is failing more than one class currently**

What subjects does your daughter do well & poorly in? _____

What academic goals do you have for your daughter? _____

Have you or your daughter discussed any career interests or future plans after highschool? _____

_____

GOALS

What are your expectations/goals for your daughter while being in our program?

What are your expectations/goals for yourselves as parents while your daughter is in our program?

Form Filled out by: _____ **Date: _____**
(name & relationship to client)