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

Child Developmental History

Family Counseling Center

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

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: ____

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

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? ____

DEVELOPMENTAL HISTORY

As well as you can remember, where there any developmental delays such as walking, talking, toilet trained, etc?

____

____

Any speech/language problems? ____

Any sleep problems? ____

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: ___________ **Height:** ______________________ **Allergies:** __________________________________

Medications **Name:**______________________________ **Name:**____________________________________
Dosage: ________ **Reason:** __________ **Dosage:** ________ **Reason:** _________________

Name:______________________________ **Name:**____________________________________
Dosage: ________ **Reason:** __________ **Dosage:** ________ **Reason:** _________________

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: ____

SPIRITUAL

Home Church ____

Where are you, as a family, spiritually? ____

____

____

GOALS

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

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

Form Filled out by: ______________________________________ **Date:** ________________

(name & relationship to client)