

**BELIEVING IN KIDS & FAMILIES**  
**Child Developmental History Record**

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**A. Identifications**

1. Child's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Person(s) completing this form: \_\_\_\_\_ Today's date: \_\_\_\_\_

2. Mother's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Currently employed:  No  Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

3. Father's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Currently employed:  No  Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

4. Parents are currently  Married  Divorced  Remarried  Never married  Other: \_\_\_\_\_  
Child's custodian/guardian is: \_\_\_\_\_

5. Stepparent's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Currently employed:  No  Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

**B. Development**

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery

Prenatal medical illnesses and health care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the child premature? \_\_\_\_\_ Weight and height at birth: \_\_\_\_\_

Any birth complications or problems? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. The first few months of life

Breast-fed? \_\_\_\_\_ If so, for how long? \_\_\_\_\_

Any allergies? \_\_\_\_\_

(cont.)

Sleep patterns or problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personality: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Milestones: At what age did this child do each of these?

Sat without support: \_\_\_\_\_ Crawled: \_\_\_\_\_  
Walked without holding on: \_\_\_\_\_ Helped when being dressed: \_\_\_\_\_  
Ate with a fork: \_\_\_\_\_ Stayed dry all day: \_\_\_\_\_  
Didn't soil his/her pants: \_\_\_\_\_ Stayed dry all night: \_\_\_\_\_  
Dressed self completely: \_\_\_\_\_

4. Speech/language development

Age when child said first word understandable to strangers: \_\_\_\_\_  
Age when child said first sentence understandable to a stranger: \_\_\_\_\_  
Any speech, hearing, or language difficulties? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. Health**

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Consequences?	Condition	Age	Treated by whom?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**D. Residences**

1. Homes

Dates		Location	Reason for moving	With whom
From	To			
Any problems?				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Residential placements, institutional placements, or foster care

Dates		Program name or location	Reason for placement
From	To		
Problems?			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**E. Schools**

Teacher	School (Name, district, address, phone)	Grade	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

May I call and discuss your child with the current teacher?  Yes  No

**F. Special skills or talents of child**

List hobbies, sports; recreational, TV, and toy preferences; etc.: \_\_\_\_\_  
\_\_\_\_\_

**G. Other**

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_