CENTRAL SQUARE THERAPY ASSOCIATES

Developmental History Form

Date: _____

Patient's Name_____ Parent(s) Name(s): _____

Date of Birth_____ Social Security Number _____

Who referred you (your child) to our clinic? _____

Over what concerns? _____

Identifying Information

Age: _____ Gender: Male Female

Patient's Address_____

Patient's Telephone #: _____ (h) _____(w)

Emergency Contact _____ at Telephone # _____

Patient's Primary Language _____ Interpreter Required?

☐Yes ☐No

Are other agencies Involved? Yes No If yes, please specify agency(ies)

Please describe in your own words what concerns brought you to our practice and how you hope we can be of help. Please add all information you believe is important and may be helpful in our assessment and treatment.

MAIL: 203 WASHINGTON ST. • #141, SALEM, MA • 01970
OFFICE: 150 MARKET STREET, 2ND FL.,LYNN, MA. 01902 PHONE: 781-592-6100
FAX: 781-592-1093; E-MAIL: WWW.CENTRALSQUARETHERAPY.COM

_____

_____

_____

_____

_____

Medical History

Primary Care Physician's Name _____

Address_____

Telephone Number: (w)_____(h) _____

Would you like for us to communicate our findings with your PCP? □ Yes □ No

Do you have any concerns regarding your (or your child's) physical health? □ Yes □ No

If so please describe:

Have you (or your child) had any surgeries? □Yes □ No If so please describe:

Are you (or your child) currently being treated for any acute or chronic medical conditions?

□Yes □ No If so please describe:

Do you (or your child) have any history of injuries, accidents if so please describe

Psychiatric History

Are you (or your child) currently in treatment for an emotional or behavior problem?

□ Yes □ No If yes, please list current providers.

Therapist's Name & Address: _____

Therapist's Phone #: _____

Do you give permission for us to speak with your (or your child's) current therapist?

□ Yes □ No

Are you (or your child) currently taking medication for an emotional or behavior problem? □ Yes □ No If yes, please list current providers.

Prescriber's Name & Address:

_____

Prescriber's Phone #: _____

Do you give permission for us to speak with your (or your child's) current

Prescriber's? □ Yes □ No

Have you or your child ever required treatment in a psychiatric hospital or residential treatment facility? □ Yes □ No If yes, please list

Dates	Hospital / Residential	Reason for Placement	Outcome

Have you or your child ever taken medication to help behaviors or emotions?
□ Yes □ No

Please provide a detailed chronology of the medications you or your child have been treated with. Also add if medications were taken alone or in combination with other medicines. Use the other side of the page if necessary. Please describe any unusual or

adverse side effects.

Date	Medication	Reason for Taking	Dose	How well did it work?	Any side effects?

Have you or your child engaged in any behaviors that are dangerous to herself/himself (suicidal ideation, attempts, self-mutilation)? Yes No

describe_____

Have you or your child engaged in any behaviors that are dangerous to others (aggressive, threatening, hurting others) ? Yes No If yes, please describe

_____

Substance Use/Abuse History

Do you or your child (to the best of your knowledge) experiment with, use, misuse, or abuse substance? □Yes □ No

If yes, please answer the following and describe his/her substance use:

Drug	**Age Started**	**Frequency**	**Amount**	**Current Use?**
Caffeine				
Nicotine				

Alcohol				
Cannabis				
Amphetamines				
Hallucinogens				
Cocaine				
Opiods				
Inhalants				
Phenylclidine				
Special K or Ketamine				
Sedatives (klonopine, Xanax)				
Polyssubstance				
Prescription Medication				
Others				

Have you or your child ever required treatment for a substance abuse/misuse problem?

□ Yes □ No If yes, please list

Dates	**Treatment Facility**	**Reason for Placement**	**Outcome**

List all current medications:

Allergies _____ Adverse Drug Reactions: _____

Is there any known family history of unusual reactions to medications or anesthesia?

Yes No If yes Please describe _____

Family History

Often certain types of illnesses run in families. Is there any known history of any of the following in either yours or your child's mother or father's families? Check all boxes that apply or mark UK if unknown.

Has anyone in the family ever had:	**Mother**	**Father**	**Sister**	**Brother**	**Extended family**
Motor or Coordination problems?					
Problems with reading?					
Problems with math?					
Speech/Language problems					
School/Learning problems					
School/learning problems					
Autism					
Abuse (verbal, emotional, physical or sexual)					
Mental retardation					
Attention Deficit Hyperactivity Disorder					
Alcohol and/or Drug Problem					
Tic Disorder or Tourette's Syndrome					
Enuresis (bedwetting)					
Encopresis (soiling)					

Separation Anxiety Disorder					
Selective Mutism					
Dementia (Alzheimer's)					
Catatonia					
Schizophrenia Disorder					
Delusional Disorder					
Major Depression					
Dysthymia (chronic depression)					
Bipolar Disorder or Manic – Depressive Illness					
Panic Disorder					
Agoraphobia					
Obsessive-Compulsive Disorder					
Generalized Anxiety Disorder Post-Traumatic Stress Disorder					
Anorexia					
Bulimia					
Body Dysmorphic Disorder (multiple personalities)					
Sexual Disorders					
Sleep Disorders (insomnia, narcolepsy, Sleep apnea, sleepwalking, night terrors, etc…)					
Impulsive Control Disorders (kleptomania, trichotillomania, pyromania, gambling, etc….)					
Personality Disorders					
Antisocial or Conduct Disorders					
Nervous Breakdown					
Psychiatric Hospitalization					
Treatment of a psychiatric Illness with medication.					
Suicide or suicide attempts					
Violence or assaultive behavior					

Are there any other behavioral or emotional or learning problems that run in the family?

Please describe _____

_____

Developmental History

How old was the mother when you or your child were conceived?

During the pregnancy with this child was the mother healthy □ Yes □ No If no,

pleasedescribe_____

_____

During the pregnancy with this child did the mother:

Take any medications □Yes □ No If yes, Please list medication (s) and reason for use

_____

Smoke cigarettes? □Yes □ No If yes, how much and often _____

Drink alcohol? □Yes □ No If yes, how much and often _____

Take any drugs? □Yes □ No If yes, which one, how much and often _____

Were there any complications during the pregnancy? □Yes □ No If yes, please describe

_____

Was the pregnancy full term? □Yes □ No If premature, how many weeks early?

_____

How was the child (or yourself) delivered? _____ Birth Weight

_____

Were there any complications during the labor and delivery? □Yes □ No If yes, please

describe _____

APGARS (if known) _____

How long did the baby stay in the hospital? _____ were there any

problems during this day? □Yes □ No If yes, please describe _____

How was the baby's name chosen? _____

How old were you or your child when (s) he / she (you):

Behavior	**Approximate Age**	**Early**	**Average**	**Late**
Rolled over				
Sat up				
Walked				
Toilet Trained				
Said first words				
Began Using Sentences				

During the first twelve months, were you or your child:

	Yes	No		Yes	No
Difficult to feed?			Colicky?		
Difficult to get to sleep?			Alert?		
Difficult to put on a schedule			Cheerful?		
Difficult to keep busy?			Affectionate?		
Easy to comfort			Sociable?		
Overactive/In constant motion?					

Social History

Who do you (or your child) prefer to spend free time with? _____

Do you (or your child) relate well to peers? □Yes □ No Adults? □Yes □ No

Are you concerned over your (or your child's) social interactions? □Yes □ No If yes, please describe _____

Please describe some of your (or your child's) favorite interests or activities

_____

Which chores is your child responsible for around your home? Please describe

_____

Please list all family members (in or out of the house) as well as other people currently living in the home:

Name	Age	Relationship	Highest level of education or type of job	Currently living in home?

Parents are: □ Married □ Living together □ Divorced □ Separated □ Widowed

Legal History

Are you (or your child) involved with the court system? □ Yes □ No If yes, describe

_____

Is there a CHINS petition in place? □ Yes □ No If yes, who is the Probation Officer

_____

Address and phone #:_____

Do you give permission for us to speak with your (or your child's) probation officer if necessary? □Yes □ No

Are you (or your child) facing any current charges? □Yes □ No If yes, please describe

_____

School History

Name of current school/day care _____ Grade _____

Address _____

Telephone # _____ Name of Teacher(s) _____

Current Daily School Schedule _____

Has (s)he repeated a grade? □Yes □ No If yes, which grade(s)? _____

Why? _____

Is your child the target of bullying or excessive teasing? □Yes □ No If yes, please describe _____ _

Is there an Education Plan? □Yes □ No

Has (s) he ever received special help in school? □Yes □ No

Is (s) he currently receiving special/extra help in school? □Yes □ No

If Yes, please check types of services being received:

Occupational Therapy (OT) □ Resource Room □ Speech/Language □

Do you give permission for us to speak with your child's school personnel including teachers and administrators, if necessary? □Yes □ No

Strengths (Assets or Motivations or Social Supports)

List any additional information that you think that is important to be known: