PARENT/CAREGIVER REPORT OF FAMILY AND DEVELOPMENTAL HISTORY

Patient Name: _____ Caregiver(s) Completing From: _____

Patient Date of Birth: _____ Date Form Completed:_____

Patient's Gender Identity: _____ Patient's Preferred Pronouns: _____

_____

Family Background

With whom does your child live with now?

If applicable, who has legal custody?

Is any caregiver with legal custody not aware of or in support of seeking the present evaluation or treatment? If so, please describe.

Please list the other children/siblings in the family:

Name	Age	Relationship (brother, sister, step-brother, half-sister, etc.)

Do you or your child have any cultural, religious, or personal preferences that would be important in understanding and helping your child? Yes/No. If Yes, please check those that apply:

__ Appearance __ Custom __Diet __Dress __Religious __Ritual __Other, specify_____

Please list anything else that you believe to be important in appreciating your child's sense of identity (ethnic, cultural, religious, gender, sexual preference, etc.)

Please note if there are other languages spoken at home in addition to or instead of English.

Background of Parents and Other Important Caregivers

Parent or Caregiver's Name	Role (Mother, Father, Step, Foster, Grandparent, etc.)	Age	Occupation	Highest Education Attained

Please note if there is other important information to share about caregivers:

If your family has pets, feel free to list them and say something about your child's relationship with them.

Your Child's School and Vocational History

Current Grade/Year in School _____ Name and location of current school _____

Name and location of previous school (if applicable) _____

Has your child ever repeated a grade? Yes/No If yes, what grade?

Please note any educational problems and/or learning disabilities that your child has had (check all that apply):

___learning disability; specify_____ __behavior problems that affect school

__ intellectual disability __ developmental disabilities; specify _____

__ speech/language/communication difficulties; specify _____

__ other, specify _____

Please note if your child has an Individualized Education Plan (IEP) or 504 Plan. Please specify.

Please note if your child has had psychological and/or neuropsychological testing through the school district or privately. If possible, please specify approximate dates, name of evaluator, and key findings.

If your child is working, please describe their current job and any past employment history (for example, have they done well at a particular job? Have they ever been fired?).

Family's Social and Financial Circumstances

Has your family experienced stressors in the fallowing areas in the past year (please specify)?

- Housing (including neighborhood safety): Yes/No _____
- Food Security: Yes/No _____
- Other Financial Concerns (such as recent loss of income, unemployment, debt problems): Yes/No _____
- Access to Healthcare (such as problems due to distance, financial limitations, insurance): Yes/No _____

Child's Psychiatric and Psychosocial History

What are the main reasons you are seeking help for your child (or your child is seeking help) at this time?

Has your child experienced previous mental health difficulties? Yes / No If yes, please describe.

When did your child's emotional or behavioral problems begin?

Have there been any major changes in your child's life recently, such as moving, changing school, serious illness or injury, or anything else you feel has affected them?

Please list your child's hobbies, interests, and strengths. Note if they have lost interest or stopped the activity recently.

Please note if your child has experienced any of the following:

	Yes/ No	Approx. Ages	Please specify and describe (include the impact on your child)
Separation or Divorce of parents			
Death of important others			
Other difficult losses/separations			
Physical or emotional neglect			
Victim of bullying			
Victim of physical, emotional, or sexual abuse			
Other trauma (please specify)			

Please note if your child has engaged in any of the following behaviors:

Behavior	Yes/No	If yes, please describe (include approximate ages)
Intentionally harmed themselves?		
Talked about or threatened suicide?		
Attempted suicide?		
Threatened physical violence?		
Bullied others?		
Tried to physically hurt or kill someone?		
Intentionally killed or injured a pet or other animal?		
Been in trouble with the law or engaged in illegal behaviors even they did not get caught?		

Current medications (prescription and over-the-counter medications in the last week).

Name of Medication	Dosage	Frequency	Targeted Symptoms

Please list previous medications that have been tried before and reasons they were discontinued (such as negative reaction, side effects, ineffectiveness):

<u>Current</u> Mental Health Treatment:

Is your child currently receiving mental health services from anyone in addition to Dr. Bram (such as another psychologist, a psychiatrist, social worker, school counselor, etc.)? Yes / No

If Yes, please note the <u>name(s) of the clinician(s), when the treatment began,</u> and the <u>type and frequency of treatment</u> (for example, play therapy, cognitive-behavioral therapy [CBT], dialectical

behavior therapy [DBT]), medication management, family therapy, partial hospital, intensive in-home therapy)

Name of Clinician and/or Program	**Approximate Date Begun**	**Type and Frequency of Treatment**

Please share briefly what has been most helpful and least helpful about **current** treatment:

Previous Mental Health Treatments:

Please check frequency

Previous Treatment (include approximate ages)	Never	1 time	2-3 times	4+ times	Generally Helpful? (Yes / No)	Name of Clinician and/or Program
Outpatient (specify individual, family, or group therapy)						
Inpatient Psychiatric Hospital						
Residential Treatment						
Partial Hospital / Day Treatment Program						
Intensive In-home Therapy						
Other						

Please share briefly what has been most helpful and least helpful about **past** treatment:

Treatments for Alcohol and/or Substance Use

Has your child received mental health treatment for alcohol or substance use or other addictions. Yes / No

- If No, please specify if you have concerns or suspicions about your child's use of alcohol or other substances.

- If Yes, please describe.

- If Yes, please describe how your child responded to treatment. Include what was most and least helpful?

Medical History

Please note the name of your child's primary care physician and their facility: _____

Approximate date of your child's most recent physical examination: _____

Please describe if there were notable findings or recommendations from that physical examination.

Please answer the following questions about your child's past and ongoing physical health.

	Yes/ No	Past or Current	Please specify and describe (include approximate dates treatment, and effectiveness; also child's attitude toward the condition and treatment)
Major physical illness			
Head injury			
Other major injury			
Seizures			
Headaches			
Operations/Surgeries			
Other major medical treatments (note if inpatient or outpatient Procedures)			
Allergies			
Other			

Please describe your child's current vaccination status (include Covid-19 boosters).

Family Psychiatric and Medical History

Has anyone in your child's family been diagnosed with a mental health problem (such as depression, anxiety, ADHD, bipolar illness, schizophrenia, etc.)? Yes / No

- If Yes, please specify the condition and the relative's relationship to your child (for example, maternal uncle, paternal grandmother, cousin on father's side)?

Is there anyone in your child's family who has been suspected of having a mental health condition, even if they have not been formally diagnosed or treated? Yes / No

- If Yes, please specify the symptoms/suspected condition and the relative's relationship to your child (for example, maternal uncle with depression, paternal grandmother with anxiety, cousin on father's side with suspected autism)?

Has anyone in your child's family had problems with drugs, alcohol, or other addictions? Yes / No

- If Yes, please along with the relative's relationship to your child?

Has anyone in your child's family had major illness Yes / No

- If Yes, please describe.

Child's Developmental History

Prenatal Period (The following questions pertain to the birth mother.)

For a child who has been adopted, please complete this section to the best of your knowledge. There will be later items specific to adoption.

Was the pregnancy planned? Yes / No Unplanned but accepted? Yes / No

Birth mother's age during pregnancy: _____

Please describe anything notable such as fertility treatments, artificial insemination, donor egg, etc.

Please note whether or not this was birth mother's first pregnancy?

- Had the birth mother experienced losses of previous pregnancy? Yes / No

If yes, please describe: _____

Did the birth mother have regular prenatal care during the pregnancy? Yes / No

What were the birth mother's activities during the pregnancy? _____

Did the birth mother feel that the living situation or events in the home were comfortable and safe during this pregnancy? Yes / No If No, please clarify. _____

What was the birth mother's health like during the pregnancy? _____

- Please describe her emotional reactions (for example, was she nervous and apprehensive, usually happy, moody, other reactions?)

- Please circle any of the following concerns about her physical condition during pregnancy (and note duration): headaches. high blood pressure, pus in the urine, possible miscarriage, other special medical conditions _____

- Please circle any of the following symptoms that the birth mother experienced during pregnancy (and note duration): nausea, vomiting; persistent abdominal or lower back pain; spotting; excessive fatigue.

- Please indicate by circling whether the birth mother experienced any of the following illness (and note at what phase of the pregnancy): flu, Covid-19, virus, infection, measles, fever, toxemia, other illness _____

- Please indicate by circling whether any of the following apply to the birth mother during the pregnancy: falls or other accidents, alcohol or drug use, smoking

- If applicable, please list medications the birth mother was taking during the pregnancy:

Was the child born more than four weeks early? Yes / No

- If Yes, please specify, including whether a stay in the neonatal intensive care unit (NICU) was necessary and, if so, for how long?

- Approximately how long was the labor? ___hours

Relatively how easy or difficult was the labor?

Please note if there were any serious complications of delivery, threatening the life or health of the birth mother or infant?

Was the other parent/caregiver at the hospital during the birth of the child? Yes / No

In the delivery room? Yes / No

Weight of the baby at birth? _____

Did the baby breathe spontaneously and easily OR was oxygen and/or other medical assistance needed after delivery? Yes / No If Yes, please describe.

Was there anything exceptional in the baby's condition such as injury, paralysis, blueness, excessive crying? Yes / No If Yes, please describe.

If your child was <u>adopted</u>, please answer the following questions:

How was the decision to adopt made?

How long of a waiting period was there before child was available for adoption?

Where was the baby adopted from?

How much information was the family given about biological parents?

What was the reaction of the extended family to the adoption?

Is the child now aware of being adopted? Yes / No

- If Yes, when?
- If Yes, what has been explained to them and what do they understand?

Infancy

Was the baby breast-fed? ___ Bottle-fed? ___ Or received both types of feeding?___

- If combined feeding, at what age was transfer from breast to bottle made? _____
- If bottle-fed, were there difficulties in finding a suitable formula? Yes / No
- If breast-fed, (partially or completely) did the mother experience any difficulty with (circle any that apply): low milk supply, painful nursing, cracked or inverted nipples, other _____
- What was the baby's response to nursing? Active ___ Eager ___ Needed encouragement____
- Did the baby mold to mother, or stiffen and arch away? _____
- What were the mother's feelings about nursing experience?
- Which type of feeding was used? Demand? ___ Time schedule?___ Frequency _____
- Were there concerns about baby's weight gain?
- When the baby vomited, were they apt to bring up food in small amounts, or did it come up in large quantities and with force? Please describe.
- Were there times when the baby had frequent spells of colic, constipation, or diarrhea? At what ages? How was it handled? Please describe.

In the days, weeks, or months after the baby's birth, please note if the birth mother experienced any mental health difficulties (such as depression, anxiety, intrusive thoughts, confusion, reality distortions).

Please note what attitude or mood did the baby seem to express most of the time? (i.e., happy, smiling, and laughing, cuddly, whiny, seemed in pain, sad, hard to engage?)

Did the baby smile in first two months? Yes / No

Generally, babies vary in the amount of activity they show. Which of the following do you think would most nearly describe your baby during the first months of his life (please check one):

- Showed a great deal of activity, such as squirming, wiggling, kicking, and otherwise moving about so that it caused concern or difficulty. ____
- Showed very little physical activity, not even showing any increase in movement, interest or response when hungry or when played with. ____
- Showed vigorous activity when awake and when played with but was equally often observed playing quietly and generally relaxed? ____
- Other pattern (please describe) _____

Who was the primary caregiver of your child as a baby?

Who assisted the primary caregiver in the care and responsibility for the baby during infancy? How much assistance? When?

Please note if during the baby's first year of life there was anything (even if it had nothing to do with the baby) that caused unhappiness or anxiety or placed any caregiver (parent or others) under special strain?

Please list other caregivers (such as father, nanny, grandparent, etc.) of your child as a baby.

When did the baby cut their first tooth? _____months.

Please note if cutting teeth caused any special difficulty, such as excessive crying, loss of weight, anxiety, etc.?

Sleep

Each child has their own individual sleeping pattern. Describe some of your child's sleeping habits, such as: thumb sucking, rocking, requiring a special toy, blanket, or other object.

Did the baby sleep alone in a room? Yes / No If not, with whom did they share it? _____

For how long a period? _____ At what age? _____

Did the baby sleep alone in a bed? Yes / No If not, with whom did they share it? _____

For how long a period? At what age? _____

At what age did your baby begin to sleep through the night?

Were there any periods when the child habitually awoke crying and any periods in which they had to be held or rocked to fall asleep? Yes / No If Yes, at what ages? ____

- What else would soothe or quiet the child?

What is the child's present sleeping arrangement?

Please note any concerns about your child's current sleep.

Developmental Achievements and Challenges

How old was the baby when they were able to sit up alone? ___ Stand? ___ Crawl? ___

First steps? ___ Walk unaided? ___ Please describe any difficulties in achieving any of these.

Did your child experience any difficulties developing fine motor skills (such as gripping a pencil, tying shoes, using scissors)? Yes / No If Yes, please elaborate.

Has your child had any motor coordination difficulties such as confusion in regard to left-handedness or righthandedness, or frequent falling, awkwardness in throwing a ball, or riding a bicycle, etc.? Yes / No

If Yes, please elaborate.

Were there any attempts made to change left-handedness to right-handedness? Yes / No

If Yes, what kind of attempts and where were they made (home, school, etc.)?

Has your child exhibited any of the following sensory sensitivities? (please check all that apply)

Sound ___ Smell ___ Visual stimulation ___ Tactile (such as certain textures, tags, etc.) ___

Taste ___ Texture of food ___

Please elaborate on any of the sensitivities that you have noted.

Please note if your child had strong likes and dislikes of different types of food?

Was your child very slow to talk (e.g., not saying single words by age 2 or sentences by age 4)? Yes / No

If Yes, please elaborate.

At what age did the baby first speak a few isolated words, such as da-da, mama, bye-bye? ___

Speak in simple phrases? _____

Please note any speech difficulties in the following areas:

- pronouncing words? ___ Ages _____
- lisping? ___ Ages _____
- stuttering? ___ Ages _____
- other? ___ Ages _____

Did your child receive early intervention (E/I) services Yes / No

If Yes, please check all E/I services received. Speech therapy ____ physical therapy ___

occupational therapy ____ Other ____

Please elaborate on interventions and their effectiveness:

How old was the child when toilet training was started? ___

- What methods were used to establish bowel control? (State whether child was placed on a toilet or child toilet seat; how frequently; how long left to sit; what was done if the child was unsuccessful; whether enemas or suppositories were used; whether child cried or struggled.)
    - Were training methods made difficult for any physical reasons, such as constipation, diarrhea, etc.? Yes / No . If yes, please elaborate.
    - At what age was bowel control established? ____Were there any relapses and under what circumstances did these occur? Yes / No If yes, at what ages? ____
    - Does the child soil at this time? Yes / No
- What training methods were used to teach the child bladder control?
    - At what age did the child stop wetting at night? ___
    - At what age did the child stop wetting in the daytime? ___
    - Were there any relapses? Yes / No If Yes, at what age? ___
    - Does the child still have difficulties with bladder control? Yes / No

What were the child's reactions and attitudes toward toilet training?

What were the child's and the parents' reactions to thumb-sucking, masturbating, nail-biting?

Was a pacifier used? At what ages? ____

Management of Intense Emotions and Approaches to Challenging Behaviors

Did/does your child have angry outbursts, temper tantrums, or other kinds of behavior which caused you concern? Yes / No If No, please skip to section below on "Approaches to Challenging Behavior"*

If yes, did they exhibit any of the following (please check all that apply):

Scream? ___ Hurt others? ___ Withdraw? __ Stomp? ___ Hurt themselves? ___

Throw things? __ Throw themselves on the floor? __ Hold their breath? ____

Bang their head on things? ___

Please describe the physical appearance of the child during these episodes.

Did they seem to know what they were doing? Yes / No

At what age did these behaviors first occur? _____

At what age did the child have them most frequently? _____

How often did they occur? _____

At what age did these behaviors stop? _____

How were these episodes handled by each of the child's caregivers and others?

What approaches have caregivers used to address other kinds of challenging behaviors?

How did/does your child respond to discipline?

What have been the major areas in which your child required special discipline?

Which caregiver(s) ordinarily handled challenging behaviors by the child?

What were the major differences between primary caregivers in their styles of addressing challenging behaviors?

What were the major differences between parents/primary caregivers and relatives in their styles of addressing challenging behaviors?

Attachment to Caregivers and Siblings

Did/does your child seem to have a closer attachment to one parent than the other? Yes / No

If yes, how was this demonstrated?

Have there been any changes in your child's attachments over time? Yes / No

If Yes, please describe, noting when this occurred.

Has the child required caregivers or others to do things for them that they were capable of doing for themselves? Yes / No If Yes, please describe.

How was the child prepared for the birth of siblings?

By whom? What was your child's response?

Did the child show marked preferences or dislikes for any of their siblings? Yes / No

If Yes, please describe, including how your child expressed this.

Separations from Caregivers

During the early years of your child's life, was any primary caregiver frequently away or out of the home? (business trips, hospital, military service) Yes / No If yes, please describe.

Who cared for the child during separations from caregivers? _____

How did the child respond to such separations?

Did the child seem reluctant or object to being left in the care of others? Yes / No If Yes, please describe.

Did the child have any preschool or school experiences such as nursery or kindergarten in which separation from home was difficult? Yes / No If Yes, please describe.

Other Fears, Anxieties, or Trauma

Did/does the child express specific fears or have frightening dreams? Yes / No

If Yes, please elaborate and note if they caused any particular problems.

Has your child had any frightening experiences or trauma? Yes / No

If Yes, please describe the experience(s), your child's reactions, and how this was addressed.

Play

What has the child shared about daydreams, fantasies, or imaginary companions?

Have they had favorite repetitive play themes or games? Yes / No If Yes, please describe.

Did/does the child prefer playing with children of their own age? __ Older? __ Younger? __ One or two friends? __ Many of them? __

Please describe how your child has connected with peers and made friends (e.g., school, neighborhood, activities).

Attitudes Toward Sex

Please describe the extent to which and at what age your child has expressed curiosity about the origin of babies?

What is your child's current understanding of this?

To what extent has your child shown curiosity about bodily differences between boys and girls?

What is your child's current understanding of this?

What are the family attitudes toward privacy, such as closed bathroom and bedroom doors?

If applicable, how and at what age was your child prepared for menstruation?

Age of first menses? ____ What was their reaction?

If applicable, how and when was your child prepared for nocturnal emission?

Age of first nocturnal emission? ____ What was their reaction?

Please note if there is anything important to share that was not included among the questions above.

Thank you for your time and thought in completing this lengthy questionnaire.