Austin Child Guidance Center

Child Developmental & Family Profile

Name of Child: _____ _____ _____
First Middle Last Date of Birth Child's Preferred Pronoun
With what gender does your child identify? _____ (he/she/ze/they…)

Address: _____ _____
Street City Zip County
Home Phone: _____ Work Phone of Parent:_____ Cell Phone:_____
Form Completed By:_____ Date:_____

Relationship to Child:_____

Contact Information for other Parent/Caregiver

Name of other parent/caregiver: _____

Address: _____ _____
Street City Zip County
Home Phone: _____ Work Phone of Parent:_____ Cell Phone:_____
Relationship to Child:_____

List the name(s) and phone numbers of the person(s) who may be contacted in the event of an emergency. Be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law.

_____

Ethnicity:
☐White/Non-Hispanic ☐Black/Non-Hispanic ☐Hispanic ☐American Indian ☐Asian/Pacific Islander
☐Other_____ ☐Unknown
Religion: ☐ Christian (Protestant or Catholic) ☐ Jewish ☐Muslim ☐ Other_____

Reason for Seeking Services:

Please describe the main difficulty that has brought your child for evaluation or treatment:

_____
_____
_____

Do you have any concerns about your child inflicting harm to self or others? (For example, suicidal or homicidal thoughts or behaviors.) If so, please explain:

_____
_____

Family Information:

Parent's Marital Status (Please check current status)

☐ Married (Date:_____) ☐ Divorced (Date:_____)
☐ Separated (Date:_____) ☐ Widowed (Date:_____)
☐ Never Married ☐ Domestic Partners

Divorce Decree

If the child's parents were divorced then a copy of the divorce decree MUST be provided to the Austin Child Guidance Center before the family will receive services at the center.

Who currently has legal custody of the child? _____
Have either parent's rights been terminated by a court? _____
Have either parent's rights to consent to treatment or obtain records of treatment been limited or restricted by a Court Order? _____Yes _____No If the answer is "yes" then please explain:_____

_____

_____

If separated/divorced, how often does this child spend time with the other parent?

_____

Please list parents (whether in or out of home) and other family members or individuals who live in the home (siblings, relatives, boarders, etc.)

Name	Date of Birth and Age	Gender	Ethnicity	Education	Occupation	Relationship to Child	Live in or out of home?

Developmental Information

I. PREGNANCY:

Is your child donor conceived? □Yes □No If yes, then does the child know? □Yes □No

Was child adopted? □Yes □No If yes, at what age and does the child know?_____

Did mother experience any of the following?

High Blood Pressure □Yes □No Diabetes □Yes □No Depression □Yes □No

Alcohol/Drug Use □Yes □No Anemia □Yes □No Smoking □Yes □No

Serious Illness □Yes □No Other Problems □Yes □No

List any medications used during pregnancy:_____

Length of pregnancy:_____

II. LABOR & DELIVERY:

Were there any problems during labor and/or delivery? □Yes □No

Were any medications used during labor and/or delivery? □Yes □No

Was there stress or trauma during pregnancy? □Yes □No

If yes to any of these questions, then please describe:_____

_____

_____

Child's weight at birth:_____ Did child have any problems at birth? □Yes □No

If yes, please describe:_____

_____

Did the child test positive for substances (e.g., cocaine, methamphetamines, etc) at birth? □Yes □No

If yes, please describe:_____

Was the child separated from the parents after birth (NICU, adoption, etc.)? □Yes □No

If yes, then please describe:_____

_____

Name of Child:_____ Date of Birth:_____

III. EARLY DEVELOPMENT:

At what age did the child do the following things?

Smile_____ Say first words_____ Sit without help_____
Speak in sentences_____ Crawl_____ Completely weaned_____
Walk without support_____ Potty trained_____

Child's first language:_____

If not English, age at which child learned English:_____

Check any problems child had during the first year:

□ Feeding □ Sleeping □ Breathing □ Colic
□ Bowel or urinary habits □ Inability to be consoled □ Emotional responsiveness

Describe any other significant problems, injuries, hospitalizations, stressors/traumas, or major illnesses during the child's first three years of life: _____

_____

IV. EDUCATIONAL HISTORY:

School/Daycare presently attending:_____ Grade:_____

School district:_____ Teacher's name:_____

Has your child ever repeated a grade? □Yes □No If yes, which one(s)?_____

Is your child in special education? □Yes □No If yes, identifying condition:_____

_____

Does your child receive 504 accommodations? □Yes □No If yes, describe: _____

_____

Is your child in gifted/talented programs? □Yes □No

Is your child in any other special program? □Yes □No If yes, describe:_____

_____

Number of elementary schools attended _____ Number of middle schools/junior high schools attended _____ Number of high schools attended _____

Does your child require assistive technology?□Yes □No If yes, describe:_____

What does your child like the most and the least about school or daycare/babysitter?
Academic issues (grades, test taking, homework habits)
Behaviors (what you hear in parent/teacher conferences or regularly from caregivers)
Relationships with teachers, authority figures, peers

_____
_____
_____
_____
_____

V. HEALTH HISTORY:

Does your child have a history of any of the following? Check yes or no for each condition

Yes	No		Yes	No	
□	□	Allergies (other than drugs)	□	□	Hearing loss
□	□	Anemia or blood problems	□	□	Heart problems or murmur
□	□	Arthritis	□	□	High blood pressure
□	□	Asthma	□	□	HIV or AIDS
□	□	Birth defects	□	□	Hypothyroid or hyperthyroid
□	□	Blood transfusion	□	□	Inherited disease
□	□	Cancer/tumor	□	□	Kidney disease or stone
□	□	Chicken pox	□	□	Lung disease
□	□	Depression or suicide attempts	□	□	Measles/German measles
□	□	Diabetes	□	□	Pneumonia
□	□	Drug/alcohol use	□	□	Sexually transmitted disease (STD)
□	□	Ear infections	□	□	Sickle cell anemia or trait
□	□	Eating disorder, bulimia, or anorexia	□	□	Strep throat
□	□	Eczema or psoriasis	□	□	Tuberculosis (TB)
□	□	Epilepsy/seizures	□	□	Vision problems (not corrected by glasses)
□	□	Headaches	□	□	Whooping cough
□	□	Head injury	□	□	Other
□	□	*Pain--currently experiencing?	□	□	*Pain—regular or recurrent?

Yes	No	
□	□	*Nutrition--Do you have concerns about your child's daily eating habits?
□	□	*Nutrition--Has your physician ever expressed concerns about your child's eating habits or meeting his/her daily requirements?

Has your child ever used alcohol or other substances? □Yes □No
Explain: _____

Does your child have any challenges with sleep? □Yes □No
Explain: _____

What time does your child fall asleep during the week? _____ On weekends? _____

What time does your child wake up during the week? _____ On weekends? _____
Does your child have a primary health care provider? □Yes □No
If yes, then what is the name of your child's physician: _____

Date of child's last physical exam:_____ Are vaccinations current? □Yes □No

Does your child have health conditions (e.g., severe asthma) which interfere with day-to-day activities?

Explain: _____
Does your child experience chronic pain (e.g., stomachaches, headaches) which has not been evaluated by a medical professional or, despite evaluation, is poorly managed? □Yes □No

Name of Child:_____ Date of Birth:_____
Explain: _____

Has your child had a significant weight loss or gain in the past 3 months (e.g., more than 10% of body weight in young children, 10 lbs. in adolescents? □Yes □No
Explain: _____

Does your child experience dental problems that may interfere with eating or which may reflect disordered eating (e.g., eroded enamel, tooth pain)? □Yes □No
Explain: _____

Is your child noncompliant with a medical recommended special diet? □Yes □No
Explain: _____

Does your child have suspected food allergies or identified food allergies? □Yes □No
Explain: _____

Has your child had a significant change in appetite? □Yes □No
Explain: _____

Has your child exhibited worrisome eating habits (such as bingeing or inducing vomiting)? □Yes □No
Explain: _____

Has your child ever had a psychological/psychiatric evaluation? □Yes □No

If yes, when and by whom?_____

Has your child ever been hospitalized for emotional or behavioral reasons? □Yes □No

If yes, when, where, and how long?_____

Does your child have any developmental or other disabilities? (Please specify) _____

If so, list any specific accommodations needed: _____

VI. MEDICATIONS:

Please provide information for current and former medications for your child (e.g., prescriptions as well as over the counter). Also indicate herbal/homeopathic treatments your child has received:

Check here if currently taking	Name of Medication/treatment	Dates prescribed	Dosage	Reason child was taking medication	Physician who prescribed medication	Effectiveness/Side Effects

Any other health interventions or important health information:

_____

_____

_____

Allergies to Medication

Does your child have any known medication allergies? □Yes □No

If yes, list here:

Name of Medication	Reaction

VII. YOUR CHILD:

Briefly tell me about your child. What does he or she like to do? What are his/her strengths? Tell me what you like about your child.

_____
_____
_____
_____
_____
_____
_____

VIII. STRESSORS:

Below is a list of stressors that your child may have experienced. Please check all that apply and describe the stressors endorsed.

- ☐ Death
- ☐ Separation/Divorce
- ☐ Marital Conflict
- ☐ Parenting
- ☐ Moves (home, school)
- ☐ Financial
- ☐ Victim of abuse/neglect
- ☐ Perpetrator of abuse
- ☐ Substance Abuse
- ☐ Out of Home Placement
- ☐ Change of Primary Caregiver
- ☐ Victim of Sexual Abuse
- ☐ Arrest/Incarceration
- ☐ Crime victim
- ☐ Mental Health Problem
- ☐ Domestic violence
- ☐ Car Accident
- ☐ Natural Disaster
- ☐ Refugee and War Zone Trauma
- ☐ Medical Trauma/Illness/Injury
- ☐ Terrorism
- ☐ Grief over loss or death
- ☐ Community/School Violence or Bullying
- ☐ Other Trauma or Stressor

_____
_____
_____
_____

Has your child experienced abuse? _____ If yes, has this been reported? _____ Please explain:

_____
_____
_____
_____

Describe trauma experience(s) and how these have impacted your child: _____

_____
_____
_____
_____