DEVELOPMENTAL / MENTAL HEALTH FORM

Child's Name:_____ **Sex: Male / Female** **D.O.B.**_____

FAMILY HISTORY: List Names	D.O.B.	Significant Health Problems	Place ✓ if changes have occurred 2nd yr.	3rd yr
Father:				
Mother:				
Brother/Sister(s):				
*oldest first				
Other *Specify relationship				

DEVELOPMENTAL INFORMATION:	2ND	3RD
At what age did your child: crawl_____ walk_____ talk _____ toilet train _____		
Was there any difficulty, with any of the above? Yes / No If yes, please explain: _____		
Is your child potty trained? Yes / No / Somewhat		
Does your child cry easily or become cranky and you can't figure out why? Yes / No Explain: _____		
Does your child: *sleep well* *restless* *have night terrors* *resist bedtime* *take daytime naps*		
What time does your child go to bed? _____ What time does your child wake-up? _____		
What upsets your child? _____		
What calms your child? _____		
Do you feel your child may have learning difficulties? Yes / No		

DEVELOPMENTAL / MENTAL HEALTH INFORMATION FORM

MEMTAL HEALTH INFORMATION:	2ND	3RD

Does your child have problems with any of the following? HEAD START AGE

- ☐ *Depressed / Sad*
- ☐ *Nervous / Worries / Anxious*
- ☐ *Trouble going to sleep*
- ☐ *Not sleeping well*
- ☐ *Gets up too early*
- ☐ *Playing well with other children his/her own age*
- ☐ *Can't sit still for very long*
- ☐ *Unpredictable behavior*
- ☐ *Does not follow simple directions*
- ☐ *No concerns*

Does your child have problems with any of the following? EARLY HEAD START

- ☐ *Crying much of the time*
- ☐ *Looking happy*
- ☐ *Making eye contact with others*
- ☐ *Trouble going to sleep*
- ☐ *Gets up too early*
- ☐ *Being cuddled*
- ☐ *Playing with children his/her own age*
- ☐ *Engaging with other children (acting shy)*
- ☐ *Handling frustration well*
- ☐ *Frequent temper tantrums*
- ☐ *Refuses to eat*
- ☐ *Eats or drinks non-food items (18 months or older)*
- ☐ *Is afraid of certain place, animals, or things*
- ☐ *No concerns*

Does your child receive services currently or in the past from:

- ☐ *BCMH* _____
- ☐ *Akron Children's Hospital* _____
- ☐ *Cleveland Clinic Hospital* _____
- ☐ *Nationwide Children's Hospital* _____
- ☐ *PT / OT or Speech* _____
- ☐ *Thompkins Child and Adolescents* _____
- ☐ *Six Counties* _____
- ☐ *Help Me Grow* _____
- ☐ *Other* _____

Are there any other concerns with your family and / or your child you would like to share? Yes / No _____

_____

_____

Explanation for 2nd year updates (refer to items indicated with √): _____

_____

_____

Parent Initials / Date _____

Explanation for 3rd year updates (refer to items indicated with √): _____

_____

_____

Parent Initials / Date _____

_____ _____

Parent Signature **Date** **Staff Signature** **Date**

Reviewed 1/16