Beth Kanne-Casselman, MEd, MFT 805.895.6960
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Developmental & Educational Consulting
MFC41818

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Developmental and Sleep History Information

(For use with minors, 16 years of age and under.
Clients 16 years and older should complete this form with a parent and the parts of the adult form that apply to his/her current situation.)

General Information
Parents' Names and Phone Numbers:
Child's Name:
Cell phone number (if applicable):
Age and Birth Date:
Grade level and school:

Please share any significant information about the following either within the body of this form or on a separate document:

Parents' relationship to each other and brief relationship history

Pregnancy

Birth

Feeding—breast fed or bottle or combination, which and for how long

Siblings (if any) and sibling relationships

Developmental milestones (rolling over, crawling, walking, eating solid food, language, emotional, cognitive, and social development)

Preschool or day care situations

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Transitional object such as a pacifier, blanket, stuffed animal or other toy, book, etc…

Transitions in general-how have they gone, how do they go currently

Any traumatic events

Relationships with peers/other children

Favorite toys, interests, and/or activities

What do you see as your child's greatest strengths?

What do you see as your child's area/s of need or growth?

School information you wish to share

Areas of academic success and challenges

<u>Parenting Style/s</u>

How would you describe your parenting style/s?

Do you adapt to your child's schedule?

Do you have your child adapt to your schedule?

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How are tears handled?

How is communication handled in general? How about strong emotions?

Relationship and bonding with Mom? With Dad?

What is your discipline approach?

<u>For tweens and teens:</u>
How is media used in the household?

Does your child have a cell phone and does he/she use it for social purposes?

How are the issues of sex, substance use, and bullying addressed (if at all) in your household?

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This section is specifically designed for issues related to sleep and can be considered optional if the reason for treatment is not sleep-related. (Even so, this can be helpful background information.)

Early Sleep Patterns and Routines

Where did the child sleep immediately after birth?

When were changes made to this?

What were they and how did that go?

Any fears?

Nightmares or night terrors?

What have you tried and for how long?

When was your last visit to the pediatrician?

Have medical issues been ruled out?

What else would you like me to know about you, your family, and your child?

(Please use the back or additional paper as needed.)

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