DEVELOPMENTAL HISTORY FORM

Date: _____

Demographic Information:

Child's Full Name:_____ Sex: _____

Child's Nickname/Preferred Name, if applicable: _____

Age: _____ Date of Birth:_____

Grade: _____ School: _____

Child's Primary Language: _____

Language spoken at home: _____

Home Address: _____

Home Phone: _____ Okay to leave message? □ Yes □ No

Parent/Guardian #1 Name: _____

Email: _____

Cell Phone: _____ Okay to leave message? □ Yes □ No

Parent/Guardian's Occupation: _____

Parent/Guardian's Employer: _____

Parent/Guardian #2 Name: _____

Email: _____

Cell Phone: _____ Okay to leave message? □ Yes □ No

Parent/Guardian's Occupation: _____

Parent/Guardian's Employer: _____

Who referred you to this agency? _____

Initial here if you would like us to contact the referral source with feedback following your appointment: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

Primary phone number: _____

Alternative phone number: _____

Pediatrician: _____

Address: _____

Pediatrician's phone number: _____

Presenting Problem:

Briefly describe the problems/concerns:

1. _____

   _____

   _____

2. _____

   _____

   _____

3. _____

   _____

   _____

Developmental History:

Was this child adopted? □ Yes □ No

Was this child placed in your care via the foster care system? □ Yes □ No

If yes to either question above, where was your child born (City/State/Hospital Name)?

_____

How old was your child when placed in your care? _____

Prenatal Development:

Was this child was conceived through in vitro fertilization? □ Yes □ No

Did the mother or father receive medicines to increase fertility? □ Yes □ No

If yes, please indicate which medicines and dosages:

Mother:_____

Father:_____

Age of mother at time of child's birth: _____ Age of father at time of child's birth: _____

Number of ultrasounds during pregnancy: _____

Please describe any abnormal findings: _____

_____

Was the child part of a multiple birth? □ Yes □ No

If yes, was the child born first, second, etc.? _____

Complications With Pregnancy:

(Please circle any of the following complications experienced by the mother while pregnant with this child)

□ Anemia	□ High Blood Pressure	□ Low Blood Pressure
□ Gestational Diabetes	□ Toxemia	□ Bleeding
□ German Measles	□ Injury	□ RH incompatibility
□ Chronic Illness	□ Surgery	□ Domestic Violence
□ Threatened Miscarriage		

Other:_____

Please describe any of the complications endorsed above:

_____

_____

Please list and describe other complications/illnesses mother experienced during pregnancy:

_____

_____

Please list any medications prescribed to mother during pregnancy:

_____

_____

Mother's Health Habits While Pregnant:

(Please answer the following questions)

Did the mother smoke cigarettes while pregnant? □ Yes □ No
If yes, how often? _____

Did the mother drink alcohol while pregnant? □ Yes □ No
If yes, how often?_____

Did the mother use any type of drugs while pregnant? □ Yes □ No
If yes, what type and how often? _____

Did the mother consume alcohol while pregnant? □ Yes □ No
If yes, what type and how often? _____

Was the mother exposed to drugs or alcohol that was used by others while pregnant? □ Yes □ No
If yes, what type and how often? _____

Birth History:

(Please answer the following questions)

How long was labor (i.e., how many hours from first contractions to birth)?

_____

Was your baby born premature? □ Yes □ No
If yes, how many days/weeks? _____ days/weeks/months (circle one)

After birth did your child stay in:

Well-baby Nursery □ Yes □ No _____ days/weeks/months (circle one)

Neonatal Intensive Care Unit (NICU) □ Yes □ No _____ days/weeks/months (circle one)

Delivery/Post-Delivery:

(Please circle any of the following items that pertain to the delivery and post delivery of this child)

□ Natural childbirth	□ Induced	□ Breeched
□ Cesarean	□ Use of Anesthesia	□ Use of Forceps
□ Cord around neck	□ Abnormal color	□ Baby did not cry right away
□ Difficulty breathing	□ Received oxygen	□ Received transfusions
□ Received phototherapy	□ Needed a respirator	

Please describe any additional complications:

_____

_____

_____

Delivery/Post-Delivery (continued):

Please describe any medical problems your child had while in the nursery:

_____

_____

_____

Did mother and infant leave the hospital together? □ Yes □ No
If not, please provide the reason:

_____

_____

_____

Early Infant Development:

(Please check off any of the following items that describe the child in the infancy)

□ Poor weight gain	□ Failure to thrive	□ Active baby
□ Limp	□ Stiff	□ Tremors
□ Convulsions	□ Difficulty sucking	□ Difficulty chewing
□ Difficult to soothe	□ Non-responsive to caregiver's voice	
□ Sensitivity to touch	□ Sensitivity to sound	

Was the baby colicky? □ Yes □ No
If yes, how long? _____

Was the baby breast fed? □ Yes □ No
If yes, how long? _____

Was the baby bottle fed? □ Yes □ No
If yes, for how long? _____

Was/Is your child on special diet? □ Yes □ No
Please describe diet: _____

Please describe any other feeding issues?
(sensitivities, textures, reflux, resistance, refusal, preferences, difficulty swallowing, drooling, etc.)

_____

_____

_____

Developmental Milestones:

(Please note the age the following were achieved. If unsure of the age, check whether it was achieved early, late or within normal limits)

Rolled over
Age: _____
□ Early □ Normal □ Late

Sat without support
Age: _____
□ Early □ Normal □ Late

Grasped pencil/crayon
Age: _____
□ Early □ Normal □ Late

Crawled
Age: _____
□ Early □ Normal □ Late

Stood up
Age: _____
□ Early □ Normal □ Late

Walked holding on
Age: _____
□ Early □ Normal □ Late

Walked without holding on
Age: _____
□ Early □ Normal □ Late

Fed self
Age: _____
□ Early □ Normal □ Late

Dressed self
Age: _____
□ Early □ Normal □ Late

Tied shoes
Age: _____
□ Early □ Normal □ Late

Pedaled tricycle
Age: _____
□ Early □ Normal □ Late

Rode bike
Age: _____
□ Early □ Normal □ Late

Grasped pencil/crayon
Age: _____
□ Early □ Normal □ Late

Swam
Age: _____
□ Early □ Normal □ Late

Babbled
Age: _____
□ Early □ Normal □ Late

Spoke first words
Age: _____
□ Early □ Normal □ Late

Put two words together
Age: _____
□ Early □ Normal □ Late

Spoke in short sentences
Age: _____
□ Early □ Normal □ Late

Language Development:

At what age was your child easily understood by others when he or she spoke? _____

Is your child's speech:

□ Usually loud □ Usually soft □ Hoarse, breathy, or strained-sounding
□ Dysfluent, choppy, or broken

Please circle the following items that relate to your child's current reception and expression of verbal communication:

□ Often asks others to repeat what they have said
□ Unable to understand what you are saying
□ Unable to follow one-step directions
□ Unable to follow multi-step directions
□ Unable to remember short messages
□ Unable to respond correctly to yes/no questions
□ Unable to respond correctly to who/what/where/when/why questions
□ Has a hard time expressing his/her ideas
□ Has a hard time asking for help/or making his/her wants and needs known to others
□ Child does not enjoy listening to stories

Please check the following items that relate to your child's manner of expression:

□ Body language
□ Single words
□ Sounds (vowels and vocalizations)
□ 2 to 4 word sentences
□ Repeats sounds, words, or phrases over and over
□ Names things around the house and/or people
□ Mispronounces words or leaves off sounds in words
□ Leaves off small words (the, is, to) when speaking in sentences
□ Leaves off endings (plurals, -ed) when speaking in sentences
□ Child avoids/resists/dislikes being read to
□ Gets frustrated when explaining things orally
□ Trouble finding words s/he wants to use
□ Talks around an issue without coming to the point
□ Speech Filled with "um" and "you know"
□ Unable to be understood by familiar others
□ Unable to be understood by unfamiliar others

Has your child ever had speech therapy? □ Yes □ No

If yes, please specify where and when. If possible, please give any information related to goals at that time or currently:

_____

_____

_____

Current Sensorimotor Function:

(Please circle he following items that relate to your child's sensory and motor skills)

Tactile (Touch):

□ Over sensitive to clothing/textures/foods □ Under sensitive to clothing/textures/foods

□ Has trouble managing personal/physical space

Visual:

□ Avoids eye contact with others □ Has trouble copying words from the board

□ Has passed most recent vision screening

□ Has trouble tracking (following) objects with eyes

Auditory (Sound):

□ Passed most recent hearing screening □ History of PE tubes in his/her ears

□ History of frequent ear infections □ Sensitive to loud sounds (school bells, sirens)

□ Fails to listen, or pay attention to what is said to him/her

Describe the difficulty (What happens? What does the child do to cope with this difficulty?):

_____

□ Has difficulty if 2 or 3 steps instructions are given at once

Describe the difficulty (What happens? What does the child do to cope with this difficulty?):

_____

□ Talks excessively □ Does not wait his/her turn

Taste & Smell:

□ Picky eater

What will the child eat? _____

What does the child refuse? _____

□ Has trouble eating different textured foods

What textures does the child struggle to eat? _____

□ Sensitive noxious smells/tastes

Which smells/tastes? _____

□ Insensitive to noxious smells/taste

□ Prefers spicy foods □ Prefers sour foods □ Prefers bitter foods

□ Prefers salty foods □ Prefers sweet foods □ Prefers hot foods

□ Prefers cold foods

□ Eats objects, substances, or materials not meant for consumption (dirt, paper, wood chips, etc.)

Which objects, substances or materials?_____

Vestibular (Movement):

□ Loses balance easily
□ Bumps into things often
□ Likes rough housing, jumping, crashing games
□ Get carsick easily
□ Prefers to be sedentary (on computer/ TV) rather than play outside?

Muscle Tone:

□ Slouches when sitting on floor/chair
□ Gets tired easily playing or writing
□ Seems generally weak compared to other children
□ Has a hard time holding his/her head up
□ Can be described as having "floppy" muscle tone

Coordination:

□ Has difficulty with sequential tasks; dressing, buttoning, making bed
□ Has difficulty playing on playground equipment
□ Has difficulty holding a pencil or crayon in a 3-point position
□ Does not enjoy sports
□ Poor ball skills for P.E. type activities
□ Seems clumsy, awkward
□ Bumps into furniture, people often
□ Left-Handed
□ Right-Handed
□ Mixed hand preference/Ambidextrous
□ Poor handwriting
□ Has trouble using both hands together easily (opening milk carton, water bottle etc.)
□ Cannot ride a bike
□ Cannot tie shoelaces

Sleep:

What time does your child go to sleep? _____ PM

What time does your child wake up? _____ AM

Please briefly describe your child's nightly sleep routine:

_____

_____

_____

Sleep (continued):

Does your child sleep in his/her own room? □ Yes □ No

If yes, at what age did your child begin to sleep alone? _____

(Please check the following items that relate to your child's sleep):
□ Difficulty staying asleep
□ Difficulty falling asleep
□ Frequent wakening
□ Sleep walking
□ Night sweats
□ Nightmares
□ Enuresis
□ Encopresis
□ Recurrent nightmares

Describe any past or present concerns/difficulties regarding your child's sleep patterns:

_____

_____

_____

Toileting:

(Please note when the following milestones were achieved):

Trained for urine
Age: _____
□ Early □ Normal □ Late

Trained for bowels
Age: _____
□ Early □ Normal □ Late

Please describe any applicable difficulties listed below, including frequency in the space provided:

Bed-wetting after training:

_____

Urine accidents during the day:

_____

Night-time soiling after training:

_____

Soiling during the day:

_____

Behavior:

(Please check any of the following items that seem to accurately describe your child's personality or behavior):

□ Shy	□ Immature	□ Well-behaved
□ Stubborn	□ Impulsive	□ Temper-tantrums
□ Cries easily	□ Cries excessively	□ Tells lies
□ Thumb-sucking	□ Head-banging	□ Tics and Twitching
□ Always in motion	□ Excessively fidgety	□ Difficulty paying attention
□ Difficulty with transitions	□ Difficulty finishing a task	□ Disorganized
□ Forgetful	□ Angry	□ Gets easily frustrated
□ Has poor self-esteem	□ Fears making mistakes	□ Harm to animals
□ Willing to try new activities	□ Attentive	□ Destructive/aggressive
□ Fears of looking "stupid"	□ Moods change quickly	□ Cooperative
□ Impulsive	□ Sees things that are not there	□ Hears voices that are not there
□ Engages in risky behavior	□ Lacks judgment	□ Uses drugs
□ Drinks alcohol	□ Skips school/classes	□ Refuses to go to school
□ Difficulty sharing	□ Difficulty listening	□ Difficulty understanding jokes
□ Self-abusive behavior	□ Withdrawn	□ Argumentative
□ Poor awareness of time	□ Gets lost easily	□ Becomes frightened easily
□ Frequent Accidents	□ Avoids being the center of attention	
□ Steals things	□ Failure to take responsibility for actions	
□ Blames others	□ Seems unable to empathize with others	

□ Rigid/Inflexible/unwilling to try new activities or new ways of doing things
□ Difficulty staying at one task for a long period of time
□ Gets distracted while watching television
□ Moods seem to be connected with the seasons
□ Difficulty making or keeping eye contact
□ Difficulty separating from caregiver
□ Plays alone for a reasonable length of time

Compulsions (please list): _____

Obsessions (please list): _____

Fears (please list): _____

Suicidal (If yes, please explain nature of ideation or attempt):

_____

_____

Homicidal (If yes, please explain nature of ideation or attempt):

_____

_____

Medical History:

(Please indicate whether your child experienced any of the following conditions):

Adenoidectomy □ Yes □ No
If yes, please give age of onset/occurrence: _____

Tonsillectomy □ Yes □ No
If yes, please give age of onset/occurrence: _____

Braces or other orthodontic appliances □ Yes □ No
If yes, please give age of onset/occurrence: _____

Ear infections □ Yes □ No
If yes, please give age of onset/occurrence: _____

Ear tubes □ Yes □ No
If yes, please give age of onset/occurrence: _____

Meningitis □ Yes □ No
If yes, please give age of onset/occurrence: _____

Encephalitis □ Yes □ No
If yes, please give age of onset/occurrence: _____

Diabetes □ Yes □ No
If yes, please give age of onset/occurrence: _____

Asthma □ Yes □ No
If yes, please give age of onset/occurrence: _____

Allergies □ Yes □ No
If yes, please list: _____

Seizures □ Yes □ No
If yes, please give age of onset/occurrence: _____

Head injury which required medical attention □ Yes □ No
If yes, please describe: _____

Loss of consciousness □ Yes □ No
If yes, please describe: _____

Heart defects □ Yes □ No
If yes, please describe: _____

Medical History (continued):

Please describe any hospitalizations or injuries your child has had:

Please report any medical diagnoses or conditions:

Please indicate whether your child complains of any of the following conditions and note the frequency of complaints in the space provided:

Headache □ Yes □ No

Nausea □ Yes □ No

Vomiting □ Yes □ No

Weakness □ Yes □ No

Dizziness □ Yes □ No

Stomach ache □ Yes □ No

Aches or pains □ Yes □ No

Trouble with hearing □ Yes □ No

Chronic constipation □ Yes □ No

Trouble with vision □ Yes □ No

Previous Medications:

Please list all previous medications that were taken for more than one month:

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Current Medications:

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Vision:

Vision impairments □ Yes □ No If yes, please describe:

_____

Glasses □ Yes □ No If yes, for what reason:

_____

Date of last vision screen: _____ Results: _____

_____

Hearing:

Hearing impairments □ Yes □ No If yes, please describe:

_____

Date of last hearing screen: _____ Results: _____

_____

Other Medical/Behavioral/Mental Health Information:

Please explain if you consulted with any other medical specialists for your child:

_____

_____

_____

Does your child have a diagnosis from a pediatrician, psychologist, psychiatrist, or other professional? □ Yes □ No
If yes, please describe: _____

_____

_____

Has child received any psychological or psychiatric treatment? □ Yes □ No
If yes, please describe: _____

_____

_____

Were improvements noted? □ Yes □ No
If yes, please describe: _____

_____

_____

Has the child ever experienced any parental separations, divorce, or death?
If yes, when? _____

How old was the child at the time? _____

Please describe the circumstances: _____

_____

_____

Does the child have trouble separating now? □ Yes □ No
If yes, please describe: _____

_____

_____

Educational History:

Child attended nursery school □ Yes □ No

Child attended Kindergarten □ Yes □ No

What (if any) problems were reported?

_____

_____

_____

List all prior schools attended (and years of attendance):

_____

_____

_____

Current School:

_____

Teacher's name:

_____

School Address:_____

School Phone Number:_____

Current Grade Level: _____

Current GPA/Grades:_____

Describe areas in which child excels at school:

_____

_____

Describe any problems at school:

_____

_____

Retentions (Grade):

_____

_____

Educational History (continued):

Suspensions (Grade):

_____

_____

_____

Is your child in a regular education classroom? □ Yes □ No

Is your child currently or have they had previous special ed/placements? □ Yes □ No
(If your child has an Individualized Education Plan or 504 Plan, please provide copies of these plans)

If yes above, at what age was the child was placed in special education? _____

Please describe what supports/services are provided by your child's school:

_____

_____

_____

Please describe any noted improvements:

_____

_____

_____

Please describe any private support/services your child receives:

_____

_____

_____

Has school psychological testing been completed? □ Yes □ No

Testing results: (please provide copies of previous testing)

_____

_____

_____

Educational History (continued):

Please check any of the following problems reported by your child's school or teacher:

□ Reading	□ Writing	□ Math
□ Behavior	□ Social Adjustment	□ Attention Span
□ Spelling	□ Distractibility	□ Hyperactivity
□ Following Directions	□ Getting along with other children	
□ Getting along with teachers	□ Does not complete homework readily	

Please describe your child's attitude towards school:

_____

_____

_____

Has your child ever missed an extended amount of school?
If so, please explain:

_____

_____

_____

Has your child ever had any of the following evaluations performed in school or privately? (Please provide copies of all prior test reports)

Physical Therapy □ Yes □ No

Name of Evaluator: _____ Date of Evaluation: _____

Findings: _____

_____

_____

Speech & Language □ Yes □ No

Name of Evaluator: _____ Date of Evaluation: _____

Findings: _____

_____

_____

Educational History (continued):

Psychological Testing □ Yes □ No

Name of Evaluator: _____ Date of Evaluation: _____

Findings: _____

_____

_____

Audiology □ Yes □ No

Name of Evaluator: _____ Date of Evaluation: _____

Findings: _____

_____

_____

Occupational □ Yes □ No

Name of Evaluator: _____ Date of Evaluation: _____

Findings: _____

_____

_____

Neurology □ Yes □ No

Name of Evaluator: _____ Date of Evaluation: _____

Findings: _____

_____

_____

Other □ Yes □ No

Name of Evaluator: _____ Date of Evaluation: _____

Findings: _____

_____

_____

Educational History (continued):

Has your child ever received any of the following therapies in school or privately? If so, please provide dates and scope of services.

Physical Therapy: _____

_____

_____

Occupational Therapy: _____

_____

_____

Speech and Language Therapy: _____

_____

_____

Counseling: _____

_____

_____

Psychologist: _____

_____

_____

Other: _____

_____

_____

Has your child ever been admitted or assessed at a psychiatric hospital? □ Yes □ No
If yes, please provide hospital name, dates, and reasons for child's assessment/admission:

_____

_____

_____

_____

_____

Social And Emotional Development:

Describe your child's current social skills and peer relationships:

Please note if your child has a history of being bullied/teased or has been aggressive in play with others:

How would you describe your child socially? How do you think your child interacts with peers while at school?

Does your child have difficulty keeping friends?

Does your child have a best friend?

What special interests does your child have?

Social And Emotional Development (continued):

Please list your child's favorite hobbies, activities, and games, other than sports (e.g. piano, books, dolls, crafts, cars, etc.). Please describe how well you feel your child does in these areas:

Which sports does your child most enjoy playing? Describe how well your child does in these sports compared to peers:

Please list any additional organizations, clubs, teams, or groups in which your child participates:

How does your child handle stress?

What are your personal child's strengths?

In what areas would you like to see your child stronger?

Is there any other pertinent information that you would like to share?

Family History:

Other Pregnancies:
List in order of birth, including the child to be seen:

Year: ____________________ Length of Pregnancy: ______________________________

Birth Weight: _______________ Sex: _________________

Complications: ____

Mother's age: ______________ Hospital where born:______________________________

Year: ____________________ Length of Pregnancy: ______________________________

Birth Weight: _______________ Sex: _________________

Complications: ____

Mother's age: ______________ Hospital where born:______________________________

Year: ____________________ Length of Pregnancy: ______________________________

Birth Weight: _______________ Sex: _________________

Complications: ____

Mother's age: ______________ Hospital where born:______________________________

Year: ____________________ Length of Pregnancy: ______________________________

Birth Weight: _______________ Sex: _________________

Complications: ____

Mother's age: ______________ Hospital where born:______________________________

Year: ____________________ Length of Pregnancy: ______________________________

Birth Weight: _______________ Sex: _________________

Complications: ____

Mother's age: ______________ Hospital where born:______________________________

Family History (continued):

Status of relationship of child's parents/guardians:

□ Intact □ Single Parent

□ Divorced □ Remarried

Names, ages, and gender of household members and family living in the home:

Who is the child's primary caregiver?

Who cares for the child when the primary caregiver is away?

Family Relations:

Are their significant marital conflicts? □ Yes □ No
If so briefly describe:

Is there conflict between child and parents? □ Yes □ No
If so briefly describe:

Is there conflict between children? □ Yes □ No
If yes, briefly describe:

Who disciplines the child and how?

Family Relations (continued):

Do parents agree on discipline? □ Yes □ No
If yes, describe disagreement related to discipline:

_____

_____

_____

Please explain how your child responds to discipline:

_____

_____

_____

Does your child have difficulty getting along with adults? □ Yes □ No
If yes, please describe:

_____

_____

_____

Does your child have difficulty getting along with brothers and sisters? □ Yes □ No
If yes, please describe:

_____

_____

_____

Describe your child's relationship with you, his/her parents:

_____

_____

_____

Circle the activities in which the child participates with the family:

□ Movies □ Meals □ Conversations
□ Visits with relatives □ Television □ Church
□ Games □ Sports □ Trips
□ Other: _____

Family Relations (continued):

Please describe your family's religious/spiritual affiliation:

_____

_____

_____

Please describe your child's religious/spiritual affiliation, if different than above:

_____

_____

_____

Conditions Affecting Child's Relatives:

(Please indicate whether any family members have a history of any of the following conditions. If yes, please note the child's relation to the family member with the condition in the space provided.)

Attention Deficit/Hyperactivity: _____

_____

Developmental Delays: _____

_____

Slowness in talking: _____

_____

Depression: _____

_____

Bedwetting/Bowel Movement: _____

_____

Anxiety: _____

_____

Bipolar Disorder: _____

_____

Withholding: _____

_____

Conditions Affecting Child's Relatives (continued):

Neurological disease: _____

_____

Seizures: _____

_____

Speech Problems: _____

_____

Intellectual disability: _____

_____

Psychiatric Hospitalization: _____

_____

Substance Abuse/Dependency: _____

_____

Autism/Pervasive Developmental Disorder: _____

_____

Learning Problems/Learning Disabilities: _____

_____

Hearing Problems: _____

_____

Visual Problems: _____

_____

Difficulty with the Law: _____

_____

Other: _____

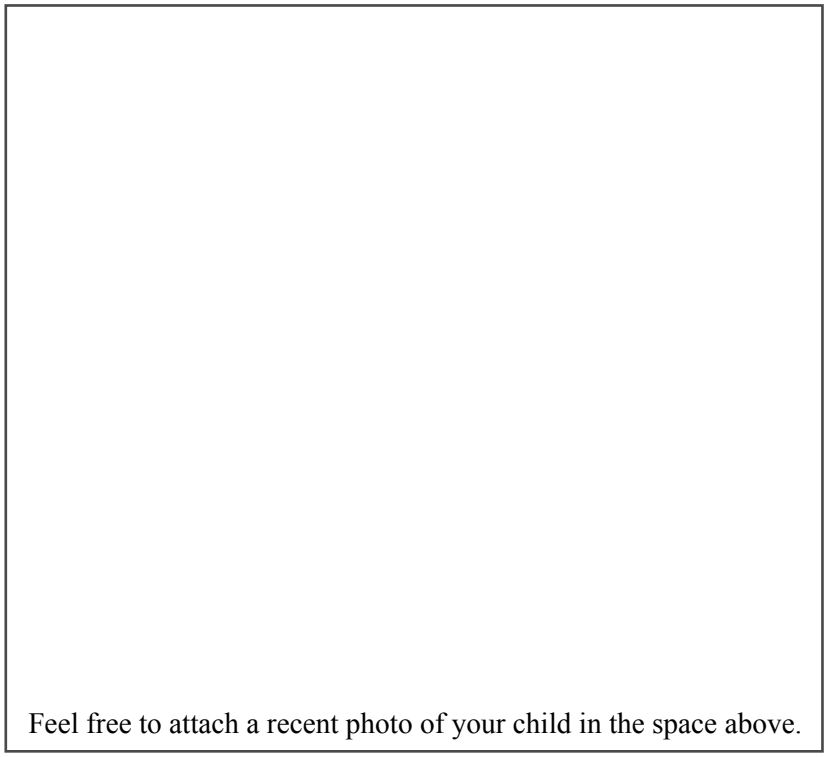
_____

Form completed by:

_____

Relationship to child:

_____



Feel free to attach a recent photo of your child in the space above.

Thank you for taking the time to complete this form! Please return it to:

_____

_____

_____

_____