



Developmental History Form

Date _____

(Please feel free to continue entries on back of pages, if needed.)

A. **Child's full name** _____

Child's Address _____

Date of Birth _____ Age _____ Sex: M F

A. **Form filled out by** _____

Phone _____ Relationship to Child _____

B. Briefly describe why you are seeking an evaluation for your child:

How long have the reasons for this evaluation existed?

Have you previously sought help? No ____ Yes ____ If yes, please describe why, where and when:

What would you like to learn from this evaluation?

C. Persons with legal custody of child (state if adoptive, step, or foster parent):

1. Name _____ Relationship to child _____

Address (if different from child's) _____

Home Phone _____ Birth Date _____ Highest Education Completed _____

Cell Phone _____ E-mail Address _____

Usual Type of Work _____ Place of Work _____

Work days/hours _____ Work Phone _____

Presently married? Yes _____ No _____ Any previous marriages? Yes _____ No _____

2. Name _____ Relationship to child _____

Address (if different from child's) _____

Home Phone _____ Birth Date _____ Highest Education Completed _____

Cell Phone _____ E-mail Address _____

Usual Type of Work _____ Place of Work _____

Work days/hours _____ Work Phone _____

Presently married? Yes _____ No _____ Any previous marriages? Yes _____ No _____

If divorced, who has legal custody of the child? _____

D. Adults and children living in child's home, if not listed above:

| Name | Age | Sex | Relationship to child (state if step, adoptive, foster, unrelated) |
|-------|-------|-------|--|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

How does child get along with his/her sibling(s)? _____

E. Child's brothers and sisters not living in child's home:

Name (state if half, step, or adoptive) Age Sex Living Where? How often does s/he see child?

F. Child care arrangements: Does anyone beside parents take care of the child on a regular basis? No Yes

If yes, please answer all that apply:

Babysitter in child's home: Hrs./wk: _____ Babysitter outside child's home: Hrs/wk _____

G. Child's Medical History

No Yes Please Describe

- | | | | |
|---|-------|-------|-------|
| 1. Medical problems during mother's pregnancy with this child | _____ | _____ | _____ |
| 2. Medications during pregnancy? | _____ | _____ | _____ |
| 3. Did mother smoke or use alcohol or drugs during pregnancy? | _____ | _____ | _____ |
| 4. Any stress during pregnancy? (such as marital, job, money, living conditions, alcohol/drug problems?) | _____ | _____ | _____ |
| 5. Problems during labor or delivery (such as prolonged labor, bleeding, breech birth) | _____ | _____ | _____ |
| 6. Was the child born prematurely? | _____ | _____ | _____ |
| 7. Birthweight: _____ lbs. _____ oz. | | | |
| 8. Problems in newborn period or infancy? (such as being born blue, birth defects, jaundice, seizures, infections, injuries, feeding or sleep problems) | _____ | _____ | _____ |
| 9. Was child challenging to care for as a baby? | _____ | _____ | _____ |
| 10. Does the child have allergies? (e.g., dust, pollen, pets) | _____ | _____ | _____ |
| 11. Does the child have eating problems? (too much/too little) | _____ | _____ | _____ |

12. Please describe below all severe illnesses, accidents, operations, handicaps and repeated medical problems (such as ear infections, headaches, broken limbs, tonsillectomy), specifying age, treatment, etc.

13. Are you concerned about any aspect of the child's health? _____

14a. Does child take any medication now for any purpose? _____ If yes, please describe below

| Name of Medication | Dose | Purpose | Effect (include side effects) | Doctor |
|--------------------|-------|---------|-------------------------------|--------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

b. Was any medication ever prescribed for behavior problems? No ___ Yes ___ Please describe:

| Name of Medication | Dose | Purpose | Effect (include side effects) | Doctor |
|--------------------|------|---------|-------------------------------|--------|
| | | | | |
| | | | | |

Child's pediatrician/physician _____ Phone# _____

Pediatrician's address _____

Date of last complete checkup _____ Outcome _____

H. Child's Developmental History

| | No | Yes | Please describe |
|--|-------|-------|-----------------|
| 1. Have you noticed any problems in development? | _____ | _____ | _____ |
| 2. Were any of the following difficult or slow to develop? | | | |
| a. walking alone | _____ | _____ | _____ |
| b. first words | _____ | _____ | _____ |
| c. combining words into phrases | _____ | _____ | _____ |
| d. bowel training | _____ | _____ | _____ |
| e. bladder training | _____ | _____ | _____ |
| f. staying dry at night | _____ | _____ | _____ |
| g. riding bike without training wheels | _____ | _____ | _____ |
| h. tying shoes | _____ | _____ | _____ |
| i. gross motor coordination | _____ | _____ | _____ |
| j. fine motor coordination | _____ | _____ | _____ |
| 3. Have there been problems in the following areas? | | | |
| a. discipline | _____ | _____ | _____ |
| b. temper or fighting | _____ | _____ | _____ |
| c. moods | _____ | _____ | _____ |
| d. relationships with others | _____ | _____ | _____ |
| e. eating | _____ | _____ | _____ |
| f. bedtime, sleeping | _____ | _____ | _____ |
| g. other behaviors (please specify) | _____ | _____ | _____ |

I. Child's Temperament

| | No | Yes | Please Describe |
|---|-------|-------|-----------------|
| 1. Is your child overactive? | _____ | _____ | _____ |
| 2. Does your child have trouble paying attention? | _____ | _____ | _____ |
| 3. Does your child have trouble staying with one activity, jumping from one thing to another, or failing to finish? | _____ | _____ | _____ |
| 4. Does your child fluctuate from happy to sad quickly with little apparent cause? | _____ | _____ | _____ |
| 5. Does your child get frustrated easily? | _____ | _____ | _____ |

6. Is your child unusually irritable? _____
7. Does your child get upset by abrupt changes? _____
8. Are your child's emotional responses unpredictable? _____
9. Does it take your child a long time to warm up to new situations or people? _____
10. Does your child react strongly to physical pain? _____
11. Does your child react strongly to other things? _____
12. Other concerns about your child's temperament? _____

J. Family History: Has any relative of the child had the following? If so, specify relationship to child.

| | No | Yes | Relationship to child | Please Describe |
|---|-------|-------|-----------------------|-----------------|
| 1. <i>Neurological</i> disease, such as seizures, fits, weaknesses, etc. | _____ | _____ | _____ | _____ |
| 2. <i>Medical</i> disease, such as diabetes, thyroid disease, heart disease, etc. | _____ | _____ | _____ | _____ |
| 3. <i>Mental</i> illness (schizophrenia, manic depressive episodes, etc.) | _____ | _____ | _____ | _____ |
| 4. <i>Physical or sensory</i> disabilities (motor, vision, sight, etc.) | _____ | _____ | _____ | _____ |
| 5. Mental retardation | _____ | _____ | _____ | _____ |
| 6. Learning problems | _____ | _____ | _____ | _____ |
| 7. Behavior problems | _____ | _____ | _____ | _____ |
| 8. Excessive use of alcohol | _____ | _____ | _____ | _____ |
| 9. Excessive use of drugs | _____ | _____ | _____ | _____ |
| 10. Trouble with the law | _____ | _____ | _____ | _____ |
| 11. Trouble holding a job | _____ | _____ | _____ | _____ |
| 12. Suicidal behavior | _____ | _____ | _____ | _____ |
| 13. Other (please specify) | _____ | _____ | _____ | _____ |

K. Current Living Situation

| | Yes | No | Please Describe |
|--|-------|-------|-----------------|
| 1. Has anyone in your family seen a psychologist, psychiatrist or other mental health worker? If yes, why? | _____ | _____ | _____ |
| 2. Have there been recent major changes or stresses in your living situation or family? | _____ | _____ | _____ |

L. Child's School History

1. Did your child ever receive Early Intervention services (infant/toddler or preschool)? Yes _____ No _____

If yes, what kind and where? _____

How often (frequency and time/session)? _____ For how long (duration)? _____

2.. Did child attend preschool? Yes ____ No ____ Where? _____ How long? _____

Any problems during that time? Yes ____ No ____ Please describe:

3. Has your child had learning problems? No ____ Yes ____ If yes, please describe below.

4. Please list all schools your child has attended thus far since preschool.

Elementary School(s) _____

Intermediate/Middle School(s) _____

High School(s) _____

College(s) _____

3. Has your child ever repeated a grade? No ____ Yes ____ Grade ____ If yes, why, and what was the outcome?

3. Has your child had social or behavioral problems in school? No ____ Yes ____ If yes, please describe.

4. Has the child ever had a psychoeducational evaluation? No ____ Yes ____ When? _____

By whom? _____

What were the findings?

5. Is your child receiving special help at school right now? No ____ Yes ____ If yes, please describe below.

6. Any other school concerns? No ____ Yes ____ If yes, please describe below

M. Other Information

1. In what groups and leisure activities does your child participate?

2. Please describe your child's strengths.

3. What do you see as your child's weaknesses?

4. Please feel free to write down anything else you think I should know.

Thank you very much!