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Developmental History Form

Date _____

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

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

Child's Address: _____

Child's Alternate Address (if applicable):

Date of Birth _____ Age _____ Sex: M F Current Grade: _____

Current School: _____ School District: _____

A. **Form filled out by** _____

Phone _____ Relationship to Child _____

B. **Briefly describe why you are seeking this re-evaluation for your child:**

What would you like to learn from this evaluation?

C. Persons with legal custody of child (current status):

1. Name _____ Relationship to child _____

Address _____

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 above) _____

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 currently has legal custody of the child? _____

D. Adults and children living in child's home(s), 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. Does anyone beside parents take care of the child or work with the child at home 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 _____

Professional Support Person(s): (eg tutor, PCA, TSS, MT, BSC, etc)

Name: _____ Role: _____ Hrs/wk: _____

Name: _____ Role: _____ Hrs/wk: _____

Name: _____ Role: _____ 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? _____ _____ _____

NO YES

14a. Does child currently take any medication?

____ ____ If yes, please describe below

Name of Medication	Dose	Purpose	When Prescribed?	Effect (include side effects)
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b. Was medication ever prescribed for behavior problems?

____ ____ If yes, please describe below

Name of Medication	Dose	Purpose	When Prescribed?	Effect (include side effects)
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15. Child's pediatrician/psychiatrist/physician(s):

Name: _____ Phone# _____

Physician's address/place of work: _____

Specialty _____ Date of last visit _____ Outcome _____

Name: _____ Phone# _____

Pediatrician's address/place of work: _____

Specialty _____ Date of last visit _____ Outcome _____

16. Did/does the child work with a psychologist/therapist(s):

Name: _____ Phone# _____

Provider's address/place of work: _____

Specialty _____ Presenting Problem _____

When did treatment start? _____ Date of last visit _____ Outcome _____

Name: _____ Phone# _____

Provider's address/place of work: _____

Specialty _____ Presenting Problem _____

When did treatment start? _____ Date of last visit _____ 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. Autism Spectrum Disorders	_____	_____	_____	_____
8. Attention Deficit Disorders	_____	_____	_____	_____
9. Behavior problems	_____	_____	_____	_____
10. 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 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. Please list all schools your child has attended thus far since preschool.

Elementary School(s) _____

Intermediate/Middle School(s) _____

High School(s) _____

College(s) _____

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

5. Has your child had learning problems in school? No ____ Yes ____ If yes, please describe.

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

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

By whom? _____

What were the findings?

8. Has your child received special education support at school? No ____ Yes ____ If yes, please describe below.

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

10. Any other school concerns? No ___ Yes ___ If yes, please describe below

11. Did/does your child obtain any of the following private therapeutic services (not already mentioned)?

Speech & Language Therapy ___ Occupational Therapy ___ Physical Therapy ___ Other ___

(please specify below)

Name: _____ Phone# _____

Provider's address/place of work: _____

Specialty _____ Presenting Problem _____

When did treatment start? _____ Date of last visit _____ Outcome _____

Name: _____ Phone# _____

Provider's address/place of work: _____

Specialty _____ Presenting Problem _____

When did treatment start? _____ Date of last visit _____ Outcome _____

M. Social Functioning

1. How well does your child get along with peers at school? Less than others ___ Average ___ Better than others ___

2. How well does your child play with peers outside school? Less well ___ Average ___ Better than others ___

3. How many good friends does your child have? None ___ 1 ___ 2 ___ 3 or more ___

4. How often does your child see friends outside school? Less than once/week ___ 1-2 times/week ___ 3+ times/week ___

5. Has your child been bullied at school? No ___ Yes ___ (if Yes, please describe when, for how long, what was done):

6. How would you rate your child's social skills?

Well Below Average ___ Below Average ___ Average ___ A Little Above Average ___ Well Above Average ___

7. Has your child ever attended a social skills group? No ___ Yes ___ (if yes, please describe):

N. 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!