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DEVELOPMENTAL HISTORY

Name of patient: _____ Date of birth: _____

Home address: _____
Street City State Zip

Home phone: _____ Cell phone: _____

Parent 2: _____Age: _____ Highest level of education: _____

Parent 2: _____Age: _____ Highest level of education: _____

Parents are: ☐ Married ☐ Living together ☐ Widowed ☐ Divorced ☐ Separated

If parents are divorced, who has:

Legal custody? _____ Physical custody? _____

What language(s) are spoken in this child's home? _____

If child is adopted, please note age at which they came to live with you and any known history prior to their adoption. _____

1. FAMILY HISTORY

Family history can often be helpful in understanding a child's issues. Please check any box that applies. Has anyone in the family had:

	Sibling(s)	Parents	Extended family
Motor problems?	☐	☐	☐
Reading problems?	☐	☐	☐
Speech/language problems?	☐	☐	☐
School/learning problems?	☐	☐	☐
Attention problems/hyperactivity?	☐	☐	☐
Mental illness/emotional problems?	☐	☐	☐
Seizures/epilepsy?	☐	☐	☐

Other (please describe) _____

Please list all family members and other people currently living in the home:

Name	Relationship to child	Age/Grade

2. BIRTH HISTORY

How old was the mother when she was pregnant with this child? _____

During pregnancy with this child, did the mother:

Drink alcohol? ☐ Yes ☐ No Take any recreational drugs? ☐ Yes ☐ No

Smoke cigarettes? ☐ Yes ☐ No Take any medications? ☐ Yes ☐ No

If yes to drugs or medication, please list: _____

Was the pregnancy normal? ☐ Yes ☐ No

Were the labor and delivery normal? ☐ Yes ☐ No Birth weight: _____

If no to either of the above, please describe: _____

Full term? ☐ Yes ☐ No If premature, how many weeks early? _____

During the hospital stay, did the baby have any problems? ☐ Yes ☐ No

If yes, please describe: _____

Were there any problems in the child's first year of life? ☐ Yes ☐ No

If yes, please describe: _____

3. EARLY DEVELOPMENT

How old was the child when (s)he reached the following milestones? **(**If not sure, circle estimate)

Sat up _____	Early	Average	Late
Walked _____	Early	Average	Late
Toilet trained _____	Early	Average	Late
Said first words _____	Early	Average	Late
Began using sentences _____	Early	Average	Late

During the first twelve months, was this child:

	Yes	No		Yes	No
Difficult to feed?	☐	☐	Colicky?	☐	☐
Difficult to get to sleep?	☐	☐	Alert?	☐	☐
Difficult to put on schedule?	☐	☐	Cheerful?	☐	☐
Overactive/in constant motion?	☐	☐	Affectionate?	☐	☐
Easy to comfort?	☐	☐	Sociable?	☐	☐

4. CURRENT MEDICAL

Child's pediatrician _____

Is this child generally in good health? ☐ Yes ☐ No

If no, please describe: _____

Does this child have allergies? ☐ Yes ☐ No

If yes, to what: _____

Is (s)he now taking any medicine? ☐ Yes ☐ No

If yes:

Medication:_____ Reason _____

Medication:_____ Reason _____

Medication:_____ Reason _____

Medication:_____ Reason _____

IMPORTANT: IF THE CHILD TAKES STIMULANT MEDICATION FOR ADHD (or any other medication) PLEASE GIVE THEM THE REGULAR DOSE ON TEST DAY

Are there any problems with bed-wetting? ☐ Yes ☐ No

Are there any problems with soiling? ☐ Yes ☐ No

Did this child ever have a head injury/concussion? ☐ Yes ☐ No

Does this child have frequent headaches? ☐ Yes ☐ No

Has (s)he ever eaten not edible items on a regular basis? ☐ Yes ☐ No

Has (s)he ever had a high lead level/lead poisoning? ☐ Yes ☐ No

Does (s)he have a seizure disorder? ☐ Yes ☐ No

Has this child ever had any serious illness, or hospitalization? ☐ Yes ☐ No

If yes, please describe:_____

Has this child ever had any serious illness, or hospitalization? ☐ Yes ☐ No

If yes, names of providers and reasons:

Provider:_____ Reason _____

Provider:_____ Reason _____

5. SCHOOL HISTORY

Name of school/day care _____

Address of school _____

Current grade _____ Name of teacher(s) _____

Has (s)he ever repeated a grade? ☐ Yes ☐ No If yes, which grade? _____

Has (s)he ever been suspended from school? ☐ Yes ☐ No

Is there an Individualized Education Program (IEP)? ☐ Yes ☐ No

Has (s)he ever received special/extra help in school? ☐ Yes ☐ No

Is (s)he <u>currently</u> receiving special help in school? ☐ Yes ☐ No

If yes, please check types of services being received:

☐ Occupational therapy (OT) ☐ Physical therapy (PT) ☐ Resource Room

☐ Speech/language ☐ Reading ☐ In-class LD ☐Adaptive phys. ed. ☐ Counseling

☐ Other (specify) _____

Has (s)he ever had a developmental, psychological, or educational evaluation (including school team evaluations)? ☐ Yes ☐ No

If yes, where and when was the most recent? _____

<u>IMPORTANT: PLEASE BRING COPIES OF MOST RECENT EVALUATION REPORTS AND EDUCATIONAL PLAN (IEP) WITH YOU TO THE APPOINTMENT</u>

6. SPEECH/LANGUAGE

What is child's *primary* way of communicating? ☐ Talking ☐ Signs ☐ Gestures

Does this child have any hearing problems? ☐ Yes ☐ No

Has her/his hearing ever been tested? ☐ Yes ☐ No

Last hearing/audiology evaluation:

Location: _____

Date: _____

Results: _____

Does this child have a history of frequent ear infections? ☐ Yes ☐ No

Has (s)he ever had tubes placed in her/his ears? ☐ Yes ☐ No

Does this child:

have any speech problems/difficulty speaking? ☐ Yes ☐ No

become frustrated when attempting to communicate? ☐ Yes ☐ No

have trouble understanding what is being said to her/him? ☐ Yes ☐ No

have trouble following directions? ☐ Yes ☐ No

Has (s)he ever had a Speech/Language evaluation? ☐ Yes ☐ No

If yes, where and when? _____

Has (s)he ever had Speech/Language therapy? ☐ Yes ☐ No

Is(s)he currently receiving Speech/Language therapy? ☐ Yes ☐ No

If yes, where?_____ Frequency? _____

7. MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? ☐ Yes ☐ No

Has (s)he ever had occupational therapy (OT) evaluation? ☐ Yes ☐ No

Is (s)he currently receiving OT services? ☐ Yes ☐ No

If yes, where?_____ Frequency? _____

Does (s)he have any gross motor problems (walking, running)? ☐ Yes ☐ No

Has (s)he ever had a physical therapy (PT) evaluation? ☐ Yes ☐ No

Is (s)he currently receiving PT services? ☐ Yes ☐ No

If yes, where?_____ Frequency? _____

Does this child use any adaptive devices (e.g., braces)? ☐ Yes ☐ No

If yes, please describe: _____

8. VISION

Has this child:

Ever been to an eye doctor? ☐ Yes ☐ No Date of most recent exam: _____

Have trouble seeing at a distance?	☐ Yes	☐ No
Wear glasses for distance?	☐ Yes	☐ No
Have trouble seeing up close?	☐ Yes	☐ No
Wear glasses for reading?	☐ Yes	☐ No
Ever been diagnosed with convergence insufficiency?	☐ Yes	☐ No
Ever been diagnosed with strabismus?	☐ Yes	☐ No

IMPORTANT:IF YOUR CHILD WEARS GLASSES, PLEASE BRING THEM TO THE APPOINTMENT

8. BEHAVIOR/MENTAL HEALTH

Does this child have any behavior problems at home? ☐ Yes ☐ No

If yes, please describe: _____

Does (s)he have any behavior problems at school? ☐ Yes ☐ No

If yes, please describe: _____

Have there been any significant recent changes (e.g., a move or a death? ☐ Yes ☐ No

If yes, please describe: _____

Does either child or family receive any mental health service? ☐ Yes ☐ No

If yes, name of agency/therapist _____

Location: _____ Phone _____

Reason: _____

Please describe in your own words what concerns you have about this child, and how you hope this evaluation can be helpful.

_____

_____

_____

_____

_____

_____

_____

_____

Do you feel that this child exhibits any of the following symptoms *more often than is typical* or a child of his/her age? Please check all that apply:

☐ Often touchy/easily annoyed	☐ Often bullies/threatens	☐ Depressed/irritable
☐ Often defies adult rules	☐ Initiates physical fights	☐ Diminished interest
☐ Blames others for mistakes	☐ Has used a weapon	☐ Changes in appetite
☐ Often argues with adults	☐ Physically cruel to others	☐ Sleep problems
☐ Often loses temper	☐ Cruel to animals	☐ Restless or slowed down
☐ Often angry/resentful	☐ Involved in mugging/ robbery	☐ Fatigued/low energy
☐ Deliberately annoys	☐ Rigid/perseverative thinking	☐ Feels worthless
☐ Often spiteful/vindictive	☐ Deliberately sets fires	☐ Indecisive/can't think
☐ Somatic complaints	☐ Destroys others' property	☐ Thinks about death
☐ Refuses to go to school	☐ Poor eye contact	☐ Talks about suicide
☐ Repeated nightmares	☐ Lies often	☐ Overreacts to touch/noise
☐ Unusual fears	☐ Steals	☐ Doesn't show emotions
☐ Panic attacks	☐ Unusual/repetitive play	☐ Strange or bizarre ideas
☐ Self-conscious/clings	☐ Has run away overnight	☐ Poor social interactions
☐ Worry about future events	☐ Often truant	☐ Compulsive rituals
☐ Excessive need for reassurance	☐ Motor or vocal tics	☐ Hurts self
☐ Out-of-control or "wild" behavior	☐ Extreme tantrums	☐ Past or current use of drugs or alcohol

Please place a checkmark in the one column which best describes the child:

	Not at all	Just a little	Pretty much	Very much
1. Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	☐	☐	☐	☐
2. Has difficulty sustaining attention in tasks or play activities	☐	☐	☐	☐
3. Does not seem to listen when spoken to directly.	☐	☐	☐	☐
4. Does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior failure to understand instructions)	☐	☐	☐	☐
5. Has difficulty organizing tasks and activities	☐	☐	☐	☐
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)	☐	☐	☐	☐
7. Loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools)	☐	☐	☐	☐
8. Is easily distracted by extraneous stimuli	☐	☐	☐	☐
9. Is forgetful in daily activities	☐	☐	☐	☐
10. Fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
11. Leaves seat in classroom or in other situations	☐	☐	☐	☐
12. Runs about or climbs excessively in situations where it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)	☐	☐	☐	☐
13. Has difficulty playing or engaging in leisure activities quietly	☐	☐	☐	☐
14. Is “on the go” or often acts as if “driven by a motor”	☐	☐	☐	☐
15. Talks excessively	☐	☐	☐	☐
16. Blurts out answers before questions have been completed	☐	☐	☐	☐
17. Has difficulty waiting his or her turn	☐	☐	☐	☐
18. Interrupts or intrudes on others (e.g., butts into conversations or games)	☐	☐	☐	☐

Please give any additional information that you feel is important and may be helpful in the assessment (e.g., the child's leisure interests, extracurricular activities, or anything else that you would like to add).