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Developmental History Form

Dear Family,

What is the main reason you are seeking evaluation at this time? What are the chief concerns that you would like help with?

_____

_____

_____

CURRENT SCHOOL: **GRADE:** **TEACHER**:

Check those that apply: ☐ Special Education ☐ Regular Education ☐ Resource Room ☐ Has IEP ☐ Has 504 Plan

↓→ Specify setting: ☐ 12:1:1 ☐ 6:1:1 ☐ Inclusion ☐ Other: _____

I. General Information

Child name (last, first)	Age	Grade	Birthdate
Person completing form	Relationship		Today's date
Parent/Guardian	Home phone		Cell phone
Address	City		State Zip
2nd Parent/Guardian	Home phone		Cell phone
Address (if different from above)	City		State Zip
Child's birthplace	Adopted? Yes No		If child was adopted, age at adoption

II. Family Background:

A. **Parents:**

Mother's name: (Circle: Bio – Step – Adoptive)	Present age:
Highest level of formal education completed and degrees/certificates earned:	Current profession/occupation:

Live with child full time? Yes No	Marital status: Married Separated Widowed Divorced Single, never married
Father's name: (Circle: Bio – Step – Adoptive)	Present age:
Highest level of formal education completed and degrees/certificates earned:	Current profession/occupation:
Live with child full-time? Yes No	Marital status: Married Separated Widowed Divorced Single, never married
Child resides with: Birth mother & father Birth mother only Parent & stepparent Birth father only Parent & adoptive parent Adoptive parent(s) Foster parent(s) Other adults living in child's primary home: _____	If child lives with only one parent, contact with other parent is: Frequent (sees child more than 4 days per week) Occasional (sees child at least once per week) Minimal (sees child less than once per week) None

B. Siblings and Birth Order: List the names and ages of each sibling in birth order, oldest child first, including relationship to the child (i.e., natural, half-sibling, step-sibling)

Name:	Age:	Male/Female	Relationship:(natural, half-sibling, step-sibling)
1.			
2.			
3.			
4.			

C. Familial History of Learning, Behavior, Mental Health and Neurologic Problems

Indicate whether any member of the *child's IMMEDIATE biological family* (i.e., **parents and siblings**) experienced any of the following. Please check all that apply.

Difficulty	**Relationship to Child**	**Difficulty**	**Relationship to Child**	**Difficulty**	**Relationship to Child**
autism		compulsive behaviors		learning disability	
Asperger's disorder		obsessive behaviors		special education	
inattention		anxiety		mental retardation	
hyperactivity		depression		social difficulty	
language delays		bipolar disorder		down's syndrome	
verbal apraxia		schizophrenia		epilepsy	
headache		tics		cerebral palsy	
other		other		seizures	
Please list any other brain, spinal cord, nerve problems, cancer, stroke or heart attacks before age 70:					

III. Child's Birth History: (Please respond to all items)

Were any chemical substances consumed during pregnancy? cigarettes alcohol marijuana other _____		
Were there any concerns during pregnancy, labor, and delivery? If yes, please explain:		
How was your child delivered? vaginal birth cesarean section	How many weeks gestation was your child at birth?_____	
How many days after birth was infant released from the hospital?_____Infant's weight at birth: _____		
Infant's Height at birth: _____	Other Comments:	
Please check all that apply:	Oxygen	incubator
NICU hospitalization # of days _____	problems sucking/feeding	antibiotic treatment
E jaundice biliruben lights or blankets	infantile seizures	other; Please explain

IV. Developmental History: If your child has **not acquired** the skills, please print "NA" in the box. **IF CHILD ACHIEVED SKILL ON TIME, WRITE:** WNL Handedness: Right Left

Motor Milestones:	**Age Acquired:**	**Motor Milestones: Continued**	**Age Acquired:**	**Speech/Language Milestones:**	**Age Acquired:**
Roll		Get dressed		Smiling	
Sit up unsupported		Pedal a tricycle		Babbling	
Crawl		Pedal a 2 wheeler (no training wheels)		Pointing	
Independent Walking				1st words	
Independent Toileting		Tie shoes		2-3 words paired	

V. Education History

Early Intervention? (ages 0-3) ☐ YES ☐ NO If yes, check all that apply and indicate how often (i.e., 1 hour/weekly)				
Speech/language therapy How often: _____	Occupational therapy How often: _____	Physical therapy How often:_____	Consultation with "Interventionist" How often:_____	Structured Play/Social Group How often:_____
Please describe any other types of therapies during ages 0-3:				

Was a multi-factored evaluation completed at age 3? ☐ YES ☐ NO

If yes, by which school district:_____

Preschool (Age 2) : special education inclusion setting private community preschool	
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:	
Preschool (Age 3): special education inclusion setting private community preschool	
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:	
Preschool (Age 4): special education inclusion setting private community preschool	
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:	

Between ages 3 and kindergarten did your child receive any therapies? If so please describe:

Elementary School Years:			
Kindergarten:	special education classroom	inclusion setting	regular education
1st grade:	special education classroom	inclusion setting	regular education
2nd grade:	special education classroom	inclusion setting	regular education
3rd grade:	special education classroom	inclusion setting	regular education
4th grade:	special education classroom	inclusion setting	regular education
5th grade:	special education classroom	inclusion setting	regular education
6th grade:	special education classroom	inclusion setting	regular education

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

Middle School Years:
Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

High School Years
Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

VI. Medication History:

List current and past medication (OTHER THAN "routine" medications, e.g., antibiotics for ear infections, fever medications, etc)

Is the child presently on medication? Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual reaction
1.				
2.				
3.				

Has the child previously been on medication? Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual reaction
1.				
2.				
3.				

Please indicate any drug allergies:	What problems did the allergy cause?
1.	
2.	

Please list any alternative therapies, home remedies, dietary supplements:

VII. Medical History:

Has your child had any of the following? If yes, please explain.

Problem:	If yes, please check√	Please explain:
Staring spells		
Seizures (with or w/o fever)		
Head trauma		
Headaches		
Speech problems		
Tics or repeated movements		
Weight loss		
Rapid weight gain		
Trouble with appetite		
Unexplained fevers		
Vision problems		
Hearing problems		
Heart problems		
Hay fever/asthma		
Lung problems		
Diarrhea or constipation		
Stomach or bowel problem		
Urinary tract infections		
Kidney problems		
Broken bones or joint problems		
Skin problems		
Birth marks		
Endocrine problems		

Anemia (low blood)		
Immunologic problems		
Immunization reactions		
Other?		
For girls: age at first menstrual period or none:		Regular? Yes No

VIII. **Psychological / Psychiatric / Neurological Evaluation-Treatment History:**

Has your child participated in any assessments/evaluations or received treatment through a private professional, school or other agency? If yes, please list in order:

Name of Professional/Organization:	Purpose: Diagnosis:	Report available? Yes No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? Yes No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? Yes No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? Yes No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? Yes No	Date of testing:

Has your child had any EEG's, CT scan, or MRI scans?

EEG Yes No If yes, when:_____where:_____outcome:_____

CT Yes No If yes, when:_____where:_____outcome:_____

MRI Yes No If yes, when:_____where:_____outcome: _____

IX. ADAPTIVE FUNCTIONING

SOCIAL SKILLS:	Does your child have many friends both in and out of school (i.e. go on play dates, etc.)? ☐ YES ☐ NO If no, please explain: Does your child communicate effectively with others both verbal and non-verbal (i.e. makes good eye contact, etc.)? ☐ YES ☐ NO If no, please explain: Does your child interact appropriately with others in terms of give and take, having empathy, and not behaving aggressively? ☐ YES ☐ NO If no, please explain:	AREA OF COCNERN: ☐ YES ☐ NO
SELF-CARE NEEDS:	Is your child able to take care of his or her basic self-care needs for his or her developmental level, such as brushing teeth, cleaning room, doing basic chores? ☐ YES ☐ NO If no, please explain: When it comes to organizing his or her room or personal space, is your child capable of this for his or her developmental level? ☐ YES ☐ NO If no, please explain:	AREA OF COCNERN: ☐ YES ☐ NO
ORGANIZATION	Does your child complete homework independently? ☐ YES ☐ NO If no, please explain: When it comes to organizing work space, such as a desk or backpack, or completing home work on time, does your child have difficulty? ☐ YES ☐ NO If Yes, please explain:	AREA OF COCNERN: ☐ YES ☐ NO

Thank you for completing the form.
This information will assist in the providing the best care for your child.