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Children's Developmental History Form

Child's Name: ________________________ Birth date: __________ Age: _____

School: _____________________________ Grade: _______ Held back? _____

Home Address: ____

Insurance Carrier:____

Referred By: ____

Reason for Referral: ____

____

What concerns do you have regarding your child and what questions were you hoping to answer from this evaluation?

____

____

____

____

Current services / frequency (i.e. Counseling, Occupational Therapy, Physical Therapy, Speech Therapy, Special Education)

____

____

____

Medical Care

Child's pediatrician
____________________________________Telephone___________________
Address
____

How often does this child see a doctor? _____________ Date of last visit ______

Is this child currently on medication? No Yes
If yes, indicate type and reason_____________________________________

Has this child ever had psychological/psychiatric counseling or therapy?
No Yes
If yes, counselor's name____

Telephone ____

Type of counseling ____

____

When? ____

Has this child ever had a neurological exam? No Yes
If yes, neurologist's name
____

Date of exam? ___________________

Reason for exam/findings

____

____

____

____

Other outside therapists/professionals/evaluations:

____

Parents

Mother's Name: ______________________ Stepmother? No Yes

Address: ____

Home Phone: ______________________ Work Phone: ___________________

Cell Phone: ______________________ E-mail: ___________________

Occupation: _______________________ Employer: ______________________

How long with present employer? ______ Highest grade completed? _________

Father's Name: ______________________ Stepfather? No Yes

Address If Different: ____

Home Phone: ______________________ Work Phone: ___________________

Cell Phone: ______________________ E-mail: ___________________

Occupation: _______________________ Employer: ______________________

How long with present employer? ______ Highest grade completed? _________

Does this child have other caretakers? No Yes
Names: ____

Child Care:
If primary caregivers work outside the home, please provide the following information:
Who cares for this child when caregivers are gone? _______________________
How many hours per day is this child in a child-care setting? ________________
How many different people care for this child? ___________________________

Brothers/Sisters:
Please list all brothers and sisters, and any other children living with the family.

Age	Sex	Relationship to this child	School & grade

How does this child get along with brother(s) and/or sister(s)? _______________
____

Family Relations:
In which activities does the family participate together with this child?
____
____
____

What do you find most enjoyable about this child?
____
____
____
____

What do you find most difficult about raising this child? ____________________
____
____
____

Who is mainly in charge of discipline in the home? ________________________
Do all caregivers agree on discipline? __________________________________
Describe discipline techniques: ______________________________________
____
____
____

Educational History
School Information:

Grade: _____________ School Currently Attending: ____________________

Class Type/Size: Mainstream / Inclusion / self-contained: ____________________

Resource Room? Yes No

Other Services? Yes No

School Phone: ____

Is the school aware that your child is being evaluated? YES NO

Please list all schools attended since kindergarten and reason for transfer if applicable:

School Name	Grade(s) attended	Year(s) attended	Reason for leaving

Preschool
Does or did this child attend preschool? No Yes At what age? ______
Amount of time per day ____________________
Days per week ______________________
Any problems in preschool? No Yes
If yes, describe:____

____

Kindergarten
Does or did this child attend kindergarten? No Yes
Any problems in kindergarten? No Yes
If yes, describe:____

____

Elementary/High School
Please indicate whether this child has had any of the following school experiences.

Has changed schools for any other reason than academic progression
No Yes
If yes, when and why?
Has been retained a grade in school No Yes
If yes, when and why?
Has skipped a grade in school No Yes
If yes, when and why?
Has difficulty with reading No Yes
If yes, describe:
Has difficulty with math No Yes
If yes, describe:
Gets poor grades No Yes
Describe most recent report card results:

____

____

Has been tested for special education No Yes
If yes, when?
Currently is placed in special education classes No Yes

If yes, what type of class? ___________________
Hours per day __________________

Dislikes going to school No Yes
Is absent from school frequently No Yes
If yes, why?
If in high school, when will this child graduate? No Yes
If yes, why?
Do you have any concerns about the quality of the child's school or teachers? No Yes
If yes, describe:

Pregnancy:

Was this child a planned pregnancy? No Yes
Was this child adopted? No Yes
Number of previous pregnancies/miscarriages: _____

Check any of the following complications that occurred during the pregnancy:

___ Difficulty in conception ___ Abnormal weight gain ___ Measles
___ Excessive vomiting ___ German measles ___ Flu
___ Excessive swelling ___ Emotional problems ___ Anemia
___ Vaginal Bleeding ___ High blood pressure ___ Toxemia
___ Other (Rh incompatibility, etc.) ______________________________________
___ Hospitalization during pregnancy: Reason ____________________________
___ Injuries/accidents during pregnancy: What month? _____________________
___ Medications used during pregnancy: What kind? ________________________
___ Alcohol used during pregnancy: Frequency ____________________________
___ Cigarettes used during pregnancy: Frequency __________________________
___ Other drugs used during pregnancy:

Type	Frequency	Prescription
___________________	___________________	Yes No
___________________	___________________	Yes No

Birth:

At this child's birth, what was the mother's age? _____ Father's age? _____
Was this child born in a hospital? Yes No If no, where? _______________
Length of pregnancy: _____ weeks Birth weight: _____lbs_____oz
Length of labor: _____ hours Apgar scores ______ /______
Child's condition at birth _______________________________________
Mother's condition at birth ______________________________________

Check any of the following complications that occurred during birth.

___ Forceps used ___ Breech birth ___ Labor induced
___ Caesarean delivery
___ Other delivery complications: Describe ________________________________

___ Incubator: How long? ____

___ Jaundiced: Bilirubin lights? No Yes If yes, how long? _____________
___ Breathing problems right after birth: Describe _________________________
Supplemental oxygen? No Yes If yes, how long? ________
Was anesthesia used during delivery? No Yes If yes, what kind? _________
Length of stay in hospital: Mother: _____ days Child: _____ days

Development:
At what age did this child first do the following? Indicate year/month of age.
_______ Turn over
_______ Show interest in or attraction to sound
_______ Crawl _______ Understand first words
_______ Speak first words
_______ Walk alone _______ Speak in sentences

Was this child breast-fed? No Yes When weaned? ______________
Was this child bottle-fed? No Yes When weaned? ______________
When was this child toilet trained? Days: _________ Nights? _________
Did bed-wetting occur after toilet training? No Yes
If yes, until what age? ___
Did bed-soiling occur after toilet training? No Yes
If yes, until what age? ___
Were there any medical reasons for bed-wetting or –soiling? No Yes
If yes, please describe:____________________________

Has this child experienced any of the following problems? If yes, please describe.

Walking difficulty	No	Yes
Unclear speech	No	Yes
Feeding/eating problem	No	Yes
Weight (under/over)	No	Yes
Colic	No	Yes
Sleep problem	No	Yes
Difficulty learning to ride a bike	No	Yes
Difficulty learning to skip	No	Yes
Difficulty learning to throw or catch	No	Yes

During this child's first 4 years, were there any special problems noted in the following areas? If yes, please describe.

Temper tantrums	No	Yes
Separating from parents	No	Yes
Excessive crying	No	Yes

Which hand does this child use for writing or drawing? ______________________
Eating? __________ Other (throwing, etc.)? _______________
If dominant hand is left hand, are there any other immediate family members who are also left handed? ____

Medical History:

Hearing and Vision

Ear infections? No Yes

Recurrent? No Yes Number, if known: __________

Hearing problems? No Yes

Ear tubes No Yes

Date of most recent hearing exam ________________________

Vision problems No Yes

Wears glasses or contacts No Yes

Date of most recent vision exam __________________________

Childhood Illnesses/Injuries

Please check the illnesses this child has had and indicate age (year/month).

___ Measles
___ German Measles
___ Mumps
___ Chicken pox
___ Tuberculosis
___ Whooping Cough
___ Scarlet fever
___ Rheumatic Fever
___ Diptheria
___ Meningitis
___ Encephalitis
___ Anemia
___ Fever above 104*
___ Head injury: Describe ____

Please describe other serious illnesses or operations:

Illness/Operation	Age
____	_______________
____	_______________
____	_______________

Has this child ever been on long term-medication (more than 6 months)? No Yes

If yes, when? ____________________ What kind? ______________________

Please indicate whether this child currently has any of the following problems.
If yes, describe how often.

Frequent colds No Yes

Chronic cough No Yes

Asthma No Yes

Hay fever No Yes

Sinus condition No Yes

Shortness of breath or dizziness:

With physical exertion No Yes

Activity limitation due to:

Heart condition No Yes

Heart murmur	No Yes
GI/Stomach difficulties	No Yes
Muscle pain	No Yes
	When? ____________________
	Where? ____________________
Clumsy walk	No Yes
Other muscle problems	No Yes
If yes, describe:	
Frequent rashes	No Yes
Bruises	No Yes
Sores	No Yes
If yes, describe:	
Severe acne	No Yes
Itchy skin (eczema)	No Yes
Seizures/convulsions	No Yes
If yes, describe:	
Speech Issues	No Yes
Accident prone	No Yes
Bites nails	No Yes
Sucks thumb	No Yes
Grinds teeth	No Yes
Has tics/twitches	No Yes
Bangs head	No Yes
Rocks back and forth	No Yes
Bowel movements	
In pants/bed	No Yes

Allergies

Allergy to medicine	No Yes
If yes, describe: ____	
Allergy to food	No Yes
If yes, describe: ____	
Other allergies	No Yes
If yes, describe: ____	

Family Health

Have any family members had any of the following? *If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents, if known.*

___ Cancer ________________	___ Tay-Sachs disease__________________
___ Cystic fibrosis ____________	___ Tourette's syndrome ________________
___ Diabetes ________________	___ Birth defect ________________________
___ Heart disease ____________	___ Cerebral palsy ____________________
___ High blood pressure _______	___ Substance abuse __________________
___ Kidney disease ___________	___ Behavior disorder __________________
___ Migraine headaches _______	___ Emotional disturbance ______________

___ Multiple sclerosis __________ ___ Mental illness ____________________
___ Physical handicap _________ ___ Mental retardation _________________
___ Stroke ___________________ ___ Nervousness ______________________
___ Tuberculosis _____________ ___ Seizures or epilepsy _______________
___ Alzheimer's disease _______ ___ Reading problem __________________
___ Hemophilia ______________ ___ Other learning disability _____________
___ Huntington's chorea _______ ___ Speech or language problem _________
___ Muscular dystrophy ________ ___ Food allergies ______________________
___ Parkinson's disease _______ ___ Severe head injury _________________
___ Sickle-cell anemia _________ ___ Other: Describe ____________________
____
____

Describe father's present health.
____

____

Describe mother's present health.
____

____

Has anyone in the family ever been in special education? No Yes?
If yes, who? ______________________
What type of class? ____________________________

Friendships
Please indicate how this child relates to other children.
Has problems relating to or playing with other children. No Yes
If yes, describe.
____

____

____

Frequent fights with playmates No Yes
Prefers playing with younger children No Yes
Has difficulty making friends No Yes
Prefers to play alone No Yes
Are there children in the neighborhood with whom this child could play?
No Yes
What roles does this child take in peer group games (for example, leader, aggressor, etc.?)
____
____

Recreation/Interests

What activities does this child enjoy?

Sports:

____

____

Hobbies:

____

____

Other:

____

____

Has this child's interest in participating in these activities declined recently?

No Yes

If yes, describe. ______________________________________

Behavior/Temperament

Please indicate whether this child exhibits any of the following behaviors.

Is easily overstimulated in play	No	Yes
Seems overly energetic in play	No	Yes
Has a short attention span	No	Yes
Seems impulsive	No	Yes
Lacks self-control	No	Yes
Overreacts when faced with a problem	No	Yes
Seems unhappy most of the time	No	Yes
Withholds affection	No	Yes
Hides feelings	No	Yes
Requires a lot of parental attention	No	Yes
Seems Uncomfortable meeting new people	No	Yes
Has fears	No	Yes

If yes, describe. ______________________________________

What makes this child angry? ______________________________________

____

____

Adaptive Skills

Please indicate whether this child has the following skills.

Dresses self	No	Yes
Bathes self	No	Yes
Helps with household chores	No	Yes
Buys gifts or presents for others	No	Yes
Has good table manners	No	Yes
Says "please" and "thank you"	No	Yes
Tells time accurately	No	Yes

Knows how to get help
or find home if lost No Yes

Does this child receive
an allowance? No Yes

If yes, how does he/she spend it? ___________________________________

____

____

Any other relevant information?

____

____

____

____