# Developmental History Form for Preschool Aged Children and Younger

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Child's Date of Birth</th>
<th>Child's Age</th>
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</thead>
<tbody>
<tr>
<td>Form Completed By</td>
<td>Date Form Completed</td>
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## FAMILY HISTORY

<table>
<thead>
<tr>
<th>Parent Name</th>
<th>Parent Name</th>
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<tr>
<td>Street Address</td>
<td>Street Address</td>
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<tr>
<td>City, State, Zip</td>
<td>City, State, Zip</td>
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<tr>
<td>Home Phone</td>
<td>Work Phone</td>
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<td>Cell Phone</td>
<td>Email</td>
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<tr>
<td>Education</td>
<td>Occupation</td>
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**Family Status:**

- [ ] Married
- [ ] Separated (in____/____)
- [ ] Divorced (in____/____)  
- [ ] Never Married

Does your child have step-parents?  [ ] Yes  [ ] No  If yes, please complete the step-parent information:

<table>
<thead>
<tr>
<th>Step-Parent Name</th>
<th>Step-Parent Name</th>
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<tbody>
<tr>
<td>Street Address</td>
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<td>City, State, Zip</td>
<td>City, State, Zip</td>
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<tr>
<td>Home Phone</td>
<td>Work Phone</td>
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<tr>
<td>Education</td>
<td>Occupation</td>
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</table>

Is your child adopted?  [ ] No  [ ] Yes. If yes, how old was your child at the time of adoption?  _________

Is your child aware of the adoption?  [ ] No  [ ] Yes

If separated or divorced, your child’s primary residence is with whom?  ________________________________

Name of child’s legal guardian:  _______________________________________________________________

Name of child’s foster parents:  _______________________________________________________________

Foster parents’ address:  ____________________________________________________________________

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PRESCHOOL/DAYCARE INFORMATION

<table>
<thead>
<tr>
<th>School or Daycare Name</th>
<th>Teacher’s Name</th>
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Address

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<th>Contact Person</th>
<th>Phone</th>
<th>Fax</th>
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REFERRAL INFORMATION

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<th>Primary Physician</th>
<th>Primary Physician Phone</th>
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<th>Primary Physician’s Address</th>
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<th>Referring Physician</th>
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<th>Referring Physician Address</th>
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<tr>
<th>Insurance Company</th>
<th>Will your insurance company cover this evaluation?</th>
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<tr>
<td></td>
<td>□ Yes  □ No  □ I don’t know</td>
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</table>

Why are you seeking an evaluation at the Rosenberg Center?
_____________________________________________________________________________________
_____________________________________________________________________________________

Does your child have a current diagnosis?
_____________________________________________________________________________________

Do you wish your care team to consider any specific diagnosis or questions?
_____________________________________________________________________________________
_____________________________________________________________________________________

Which symptoms or behaviors concern you most at this time?
_____________________________________________________________________________________
_____________________________________________________________________________________

What are your goals of this assessment?
_____________________________________________________________________________________
_____________________________________________________________________________________
**SOCIAL HISTORY**

Please draw the family constellation at the child’s primary residence and the residence of the child’s other parent (if living separately). Include ages of all the children and adults living in the home. Use the following illustration as an example.

![Family Constellation Illustration]

- Yes  
- No  
Have there been other adults or children living in the home either currently or in the past? If yes, what is their relationship with your child?

_______________________________________________________________________________________

- Yes  
- No  
Has your child experienced and parental separations or the death of any family members? If yes, please describe the circumstances (e.g., your child’s age and the event).

_______________________________________________________________________________________

- Yes  
- No  
Is either parent away from home for several days at a time on a regular basis?

- Yes  
- No  
Does cultural heritage play a significant role in your daily life?

- Yes  
- No  
Is either parent away from home for several days at a time on a regular basis?

- Yes  
- No  
Is your child allergic to any medications? If yes, please list medications.

_______________________________________________________________________________________

- Yes  
- No  
Are your child’s immunizations up to date?

When was your child’s last complete physical? ________________________________________________

When was your child’s hearing last screened? ________________________________________________

**PRESENT ILLNESS/CURRENT BEHAVIOR**

What is the current health status of your child?

- Excellent
- Good
- Fair
- Poor
- I don’t know

- Yes  
- No  
Do you have any specific medical concerns about your child?

_______________________________________________________________________________________

- Yes  
- No  
Does your child take medications on a daily basis? If yes, please complete the table below.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage and how often</th>
<th>How long child has taken this</th>
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</tbody>
</table>

- Yes  
- No  
Is your child allergic to any medications? If yes, please list medications.

_______________________________________________________________________________________

- Yes  
- No  
Do you have any specific medical concerns about your child?

_______________________________________________________________________________________

- Yes  
- No  
Are your child’s immunizations up to date?

When was your child’s last complete physical? ________________________________________________

When was your child’s hearing last screened? ________________________________________________
When was your child’s vision last screened? ______________________________________________________

☐ Yes ☐ No Is your child currently seeing any medical specialists or therapists (such as a neurologist, occupational therapist, physical therapist, speech and language pathologist etc)? If yes, please provide the name and clinic of the person your child is seeing.

______________________________________________________________________________________

______________________________________________________________________________________

☐ Yes ☐ No Does your child experience any of the following difficulties with sleep?
☐ Difficulty falling asleep ☐ Waking in the night ☐ Nightmares ☐ Early morning waking
☐ Night Terrors ☐ Sleeps too much ☐ Snoring ☐ Sleep Apnea
☐ Falls asleep during the day (other than age appropriate naps)
☐ Other __________________________________________________________

☐ Yes ☐ No Does your child have any of the following difficulties with eating?
☐ Difficulty sitting at table ☐ Over eats ☐ Avoids food due to texture
☐ Poor food choices ☐ Picky Eater ☐ Odd eating behaviors/habits
☐ Other __________________________________________________________

☐ Yes ☐ No Does your child frequently complain of physical symptoms not related to medical problems?
☐ Stomach aches ☐ Headaches ☐ Joint aches
☐ Fatigue ☐ Dizziness ☐ Heart Palpitations
☐ Breathing Problems ☐ Tremors/Shakes
☐ Other __________________________________________________________

☐ Yes ☐ No Does your child have any of the following difficulties with elimination?
☐ Daytime wetting ☐ Toilet refusal ☐ Night wetting
☐ Constipation ☐ Soiling ☐ Diarrhea
☐ Other __________________________________________________________

☐ Yes ☐ No Is your child exposed to tobacco use at home?

Space for Interviewer Notes:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

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**FAMILY MEDICAL HISTORY**

Please indicate all medical conditions that have occurred in the child’s biological relatives. Indicate who in the space provided. Under sibling, please indicate sister (S) or brother (B). For all other relatives, indicate which side of the family, mother (M) or father (F). For example, if the child’s mother’s sister has a learning disability, you would place “M” in the box under “Aunt” in the column labeled “learning disability”.

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>Mother</th>
<th>Father</th>
<th>Sibling</th>
<th>Aunt</th>
<th>Uncle</th>
<th>Cousin</th>
<th>Grandparent</th>
<th>Other</th>
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<tbody>
<tr>
<td>Learning Disability</td>
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<td>Pervasive Developmental Disorder</td>
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<td>Hearing Loss/Deafness</td>
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<td>Tourette or Tic disorder</td>
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<td>Chronic illness (Please list)</td>
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<td>Obsessive Compulsive Disorder</td>
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<td>Eating disorder</td>
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<td>Obesity/Weight Problem</td>
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<td>Cardiac (Heart) problems</td>
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<td>Other</td>
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☐ Yes  ☐ No  Has anyone in the child’s family (mother, sibling or father) ever received psychological assessment, treatment or hospitalization including for drug and alcohol abuse?  If yes, please explain.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>Clinic or Facility</th>
<th>Reason for Treatment</th>
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</thead>
<tbody>
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**Space For Interviewer Notes:**


**Pregnancy**

☐ Yes  ☐ No  The pregnancy was mother’s _____ of _____ pregnancies with _______ live births.

☐ Yes  ☐ No  Did any of the following occur prior to the pregnancy?
  ☐ Fertility Medications  ☐ Miscarriages

☐ Yes  ☐ No  Did any of the following occur during the pregnancy?
  ☐ Maternal injury, describe: _______________________________________________________
  ☐ Infections, describe: ____________________________________________________________
  ☐ Excessive vomiting
  ☐ Abnormal weight gain
  ☐ Poor weight gain
  ☐ Measles
  ☐ Toxemia
  ☐ Gestational diabetes
  ☐ Anemia
  ☐ Measles
  ☐ Exposure to toxins
  ☐ Hypertension
  ☐ X-rays, which months: __________________________________________________________
  ☐ Bleeding, spotting, which months: ________________________________________________
  ☐ Abnormal emotional stress (such as work hours, death of a relative, etc.)
  ☐ Prenatal testing (such as CMV, HIV, TORCH)
  ☐ I don’t know
  ☐ Alcohol use- amount per day: ____________________________________________________
  ☐ Cigarette use- amount per day: __________________________________________________
  ☐ Medication use- amount per day: ________________________________________________
  ☐ Drug use (such as cocaine, marijuana etc) which months: ____________________________

☐ Yes  ☐ No  Did any of the following complications occur during labor or delivery?
  ☐ Labor induced  ☐ Cesarean delivery
  ☐ General anesthesia  ☐ Breech delivery
  ☐ Fetal distress  ☐ Forceps delivery
  ☐ Prolonged labor ___ hrs.  ☐ Multiple birth
  ☐ Other ________________________________________________________________

**Birth History**

Mother’s age at time of delivery _______  Father’s age ____________

Hospital, city and state of birth ______________________________________________________

Length of pregnancy ________ weeks

What was your child’s weight at birth? _______lbs. _______ozs.

Apgar scores __________ 1 minute ______________ 5 minutes

What was your child’s condition at birth?
  ☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor  ☐ I don’t know

What was the length of the hospital stay for
  Infant _____________________________  Mother ______________________________
□ Yes  □ No  Did any of the following complications occur after delivery?
  □ Infection/fever
  □ Incubator  How long? _________________________________
  □ Jaundiced
  □ Breathing problems
  □ Respirator  How long? _________________________________
  □ Bleeding in the brain
  □ Difficulty with sucking/feeding
  □ Heart Problems

□ Yes  □ No  Were there any congenital defects/anomalies? (i.e., cleft palate, gastroschisis etc.)
_____________________________________________________________________________________

Medical History
□ Yes  □ No  Has your child had any of the following health problems:
  □ Seizures
  □ Asthma
  □ Chronic ear infections
  □ Ear tubes, age _____ □ Broken bones
  □ Head injury
  □ Meningitis
  □ Diabetes
  □ Lead poisoning
  □ Allergies, please list:
  □ Vision problems (e.g., wears glasses) since age _________________________________
  □ Special problems (e.g., wears glasses) since age _________________________________
  □ Hearing problems- hearing loss  □ Left ear  □ Right ear

Hospitalizations (reason)  Dates  Surgery  Date
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

□ Yes  □ No  Has your child had a medication prescribed for a behavioral or emotional problem?  If yes, please complete:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Age</th>
<th>Prescribing Physician</th>
<th>Result of Treatment</th>
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<tbody>
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Please describe your child’s temperament at the following ages

Infancy (birth-12 mos.)  □ Pleasant/happy  □ Fussy  □ Colicky  □ Other______
Toddler (12-36 mos.)  □ Pleasant/happy  □ Fussy  □ Colicky  □ Other______
Preschool (36-60 mos.)  □ Pleasant/happy  □ Fussy  □ Colicky  □ Other______

Was there anything unusual about how your child developed?  (i.e., didn’t like to be held, very early interest in numbers etc.)
_____________________________________________________________________________________

BIRTH TO ONE YEAR
□ Yes  □ No  In the first, did your infant experience any of the following problems?
  □ Breathing problems  □ Ear infections
  □ Feeding problems  □ Injury
  □ Weight loss or poor weight gain  □ Developmental delay
  □ Irritability  □ Other infections
  □ Sleep problems
ONE TO THREE YEARS

☐ Yes ☐ No From age one to three, did any of the following occur?
☐ Excessive temper tantrums ☐ Recurrent ear infections
☐ Developmental delay ☐ Sleep problems
☐ Ear tubes inserted ☐ Behavior problems
☐ Separation problems

THREE TO FIVE YEARS

☐ Yes ☐ No From age three to five, did any of the following occur?
☐ Excessive temper tantrums ☐ Recurrent ear infections
☐ Developmental delay ☐ Sleep problems
☐ Separation problems ☐ Behavior problems
☐ Toileting problems ☐ Ear tubes inserted
☐ Difficulty with structured activity ☐ High activity level
☐ Difficulty with transitions ☐ Short attention span

☐ Yes ☐ No Did preschool teachers, daycare providers or other caregivers observe difficulty with any of the following?
☐ Structured activity ☐ Group activity
☐ Behavior ☐ Attention
☐ Peer Relationships ☐ Transitions

DEVELOPMENTAL MILESTONES

At what age did your child first do the following? Please indicate age in months.

__________ Turn over
__________ Feed self with spoon
__________ Speak first words
__________ Sit alone
__________ Tie shoes
__________ Crawl
__________ Bowel trained
__________ Bladder trained
__________ Began to read
__________ Walk alone
__________ Write name
__________ Ride a bike
__________ Dry at night
__________ Use 2-3 word combinations

Has your child shown any loss of previous abilities (such as he was speaking in two word sentences, then stopped talking). Please describe. ____________________________________________________

☐ Yes ☐ No Has your child ever been diagnosed with a behavioral or emotional problem? If yes, please complete below.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Age</th>
<th>Clinician or Facility</th>
<th>Treatment</th>
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☐ Yes ☐ No ☐ I don’t know Does your child have a history of:
☐ Serious trauma or experiences ☐ Physical abuse
☐ Sexual abuse ☐ Emotional abuse

Please describe your child’s personality (e.g., sensitive, happy, compassionate, stubborn, etc.)

________________________________________________________________________
________________________________________________________________________

What do you like best about raising your child?
________________________________________________________________________
________________________________________________________________________

What are your child’s main strengths?
________________________________________________________________________
________________________________________________________________________

What are your child’s main weaknesses?
________________________________________________________________________
Are there any issues that are seriously affecting your family that you would like us to be aware of?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

DEVELOPMENTAL

What hand does your child use to complete tasks?

☐ Left  ☐ Right  ☐ Both

☐ Yes ☐ No  Does your child have problems with coordination?

☐ Large motor coordination (i.e., running, jumping, etc.)

☐ Small motor coordination (i.e., handwriting, cutting, sipping, etc.)

☐ Yes ☐ No  Does your child display any unusual repetitive movements or noises (tics)?

☐ Head, facial or neck twitches

☐ Nervous habits, describe ___________________________________________________________________

☐ Repetitive actions when excited, describe ___________________________________________________________________

☐ Problems with balance

☐ Walks in an unusual manner

☐ Walks on tiptoes

☐ Is generally clumsy

☐ Other ____________________________________________

☐ Yes ☐ No  Does your child act in any of the following ways?

☐ Frequently seems unaware of others in the room  ☐ Doesn’t play make believe games

☐ Shows an excessive reaction to noise  ☐ Preoccupied with one particular interest

☐ Failure to react to touch  ☐ Poor eye contact

☐ Over reaction to touch  ☐ High pain tolerance

☐ Echoes or repeats the same phrase over and over

☐ Repeats the same behavior over and over

☐ Sensory sensitivities (e.g., textures of foods, smells, upset by bright lights etc.)

☐ Seems unafraid of dangerous activity (e.g., shows no fear when on high play equipment)

☐ Speaks using a sing-song or high pitched intonation pattern

☐ Yes ☐ No  Do you have concerns about the way your child interacts with others?

☐ Plays along side of peers, but not with them  ☐ Shows excessive familiarity with strangers

☐ Does not seek or share enjoyment with others  ☐ Overly trusting of unfamiliar people

☐ Resists comforting by caregivers  ☐ Often overly guarded, watchful of others

☐ Shows changeable and contradictory responses to others

☐ Other __________________________________________________________________________

Space for Interviewer Notes:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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Does your child have any of the following symptoms of worrying?

- Unrealistic worry about future events
- Easily fatigued
- Frequently refuses to sleep alone
- Difficulty tolerating normal errors
- Excessive need for reassurance
- Often seems overly tense
- Shy or withdrawn
- Repeated nightmares
- Unrealistic and persistent fears about the health of or harm coming to parents, siblings or others close to him or her
- Worry about separation from those close to him or her
- Obsessive thoughts such as fear of germs
- Compulsions such as hand washing, counting, checking, ordering and lining up objects

Has your child had any of the following difficulties?

- Sad, depressed or irritable mood most of the day
- Slow moving
- Self-destructive thoughts or behavior
- Diminished pleasure in activities
- Difficulty falling asleep
- Low energy/frequently tired
- Cries easily or often

Highly distractible
- More talkative than usual
- Decreased need for sleep
- Increase in activity level

Does your child have frequent temper outbursts (e.g., yelling, hitting or stomping feet)? If yes, what triggers a temper outburst?

Please describe a typical temper outburst

What is the frequency of your child’s temper outbursts (e.g., 5-6 times a day)

Does your child have problems with physical or verbal aggression? If yes, describe.

Does your child get along well with others?

Does your child display any of these behaviors?

- Often loses temper
- Often actively defies or refuses adult requests
- Often angry or resentful
- Often touchy or easily annoyed

Does your child show any difficulties with activity level of impulsive behaviors?

Has your child had any difficulties sustaining attention on tasks or play activities?
**DISCIPLINE**

Who is in charge of disciplining your child? _____________________________________________________________

□ Yes  □ No  Do all caregivers agree on discipline? _______________________________________________________

Which of the following discipline techniques are used with your child? (Check all that apply)

- □ Time out in room  □ Removal of privileges  □ Other ________________________________
- □ Time out in chair  □ Reward for appropriate behavior  □ Spanking
- □ Taking away toys  □ Taking away computer or television time

Which of the following discipline techniques have you found most effective? _________________________________

Please describe any concerns not previously stated that you have regarding the discipline of your child. _____________________________________________________________

**EDUCATIONAL HISTORY**

□ Yes  □ No  Do you have any specific concerns regarding your child’s learning progress?

- □ Pre-academics  □ Small motor skills  □ Social skills
- □ Large motor skills  □ Behavior  □ Speech and language skills
- □ Teacher relationships  □ Peer relationships

□ Yes  □ No  Do you have concerns related to:

- □ Off task behavior  □ Attention  □ Concentration

□ Yes  □ No  Has your child had a school evaluation? If yes, what is the date of the last evaluation? _________________________________

□ Yes  □ No  Has your child been involved in any of the following educational programs?

- □ Early Childhood Special Education  □ Autism services
- □ Mental retardation/Mental Impairment  □ Emotional/Behavioral disorder program
- □ Program for Other Health Impaired  □ Home programming
- □ Speech-language therapy  □ Multiply handicapped services
- □ Occupational therapy  □ Physical therapy
- □ Teacher relationships  □ Peer relationships
- □ I don’t know the name of the program or services

**COMMUNITY RESOURCES**

□ Yes  □ No  Have you or your child been involved with any of the following resources?

- □ PCA care  □ PACER  □ Foster care
- □ ARC  □ County social worker  □ Developmental disorder social worker
- □ Respite care  □ Other _________________________________

**SPEECH AND LANGUAGE HISTORY**

□ Yes  □ No  Do you have any current concerns regarding your child’s speech or language?

□ Yes  □ No  Is your child currently receiving speech or language therapy?

□ Yes  □ No  Does your child have a history of speech or language problems?

□ Yes  □ No  Has your child received speech therapy in the past? If yes, please complete the following:

<table>
<thead>
<tr>
<th>Nature of problem (e.g. language delay)</th>
<th>Dates of service/Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

□ Yes  □ No  Does your child have a current IEP/IFSP that includes speech and language services? If yes, which of the following services are included?

- □ Expressive Language  □ Voice therapy  □ Articulation
- □ Receptive Language  □ Fluency/Stuttering  □ Other _________________________________
**RECEPTIVE/EXPRESSIVE LANGUAGE**

- **Yes**  
- **No**  
  Does your child have any of the following problems understanding language?
  - Following single part directions
  - Following multi-part directions
  - Understanding vocabulary
  - Understanding age appropriate jokes
  - Understanding questions
  - Understand idioms (such as “You’re in a pickle”)

- **Yes**  
- **No**  
  Does your child have any problems with expressive language?
  - Grammar/sentence structure
  - Maintaining topics in conversation
  - Sequencing a story from start to finish
  - Initiating conversation
  - Adjusting to a listener’s needs
  - Using appropriate vocabulary

**ARTICULATION**

- **Yes**  
- **No**  
  Does your child have any problems saying sounds correctly?
  - Specific sound errors, describe
  - Difficulty sequencing long words

**FLUENCY**

- **Yes**  
- **No**  
  Does your child have any difficulty with speech fluency?
  - Frequently stutters or stammers
  - Says “um” or “uh” a lot

**VOICE**

- **Yes**  
- **No**  
  Does your child have any problems with his or her voice?
  - Frequent screaming
  - Frequent laryngitis
  - Loud talker
  - Voice quality (harsh, hoarse, breathy or nasal voice)

**HEARING/LISTENING**

- **Yes**  
- **No**  
  Do you have any specific concerns about your child’s hearing/listening?
  - Turns volume up on TV or radio
  - Distracted by background noise
  - Says “what?” a lot
  - Complains of ringing in ears
  - Trouble determining where a sound came from
  - Misunderstands what was said often
  - Answers questions incorrectly
  - Complains of dizziness
  - Problems with balance

- **Yes**  
- **No**  
  Does your child have any difficulty using or understanding non-verbal cues?
  - Body language
  - Tone of voice
  - Facial expressions
  - Rate of speech
  - I don’t know

- **Yes**  
- **No**  
  Does your child struggle with sounding appropriate in social situations?

Thank-you very much for completing this questionnaire. This information will help us evaluate your child.