1935 County Road B2, West
Suite 100
Roseville, MN 55113
651-636-4155

Developmental History Form for Preschool Aged Children and Younger

Child's Name	Child's Date of Birth	Child's Age
Form Completed By	Date Form Completed	

FAMILY HISTORY

Parent Name		Parent Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Email	Cell Phone	Email
Education	Occupation	Education	Occupation

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:

Step-Parent Name		Step-Parent Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Email	Cell Phone	Email
Education	Occupation	Education	Occupation

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: ____

PRESCHOOL/DAYCARE INFORMATION

School or Daycare Name		Teacher's Name
Address		
Contact Person	Phone	Fax

REFERRAL INFORMATION

Primary Physician	Primary Physician Phone
Primary Physician's Address	
Referring Physician	Referring Physician Phone
Referring Physician Address	
Insurance Company	Will your insurance company cover this evaluation? ☐ Yes ☐ No ☐ I don't know

Why are you seeking and 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?

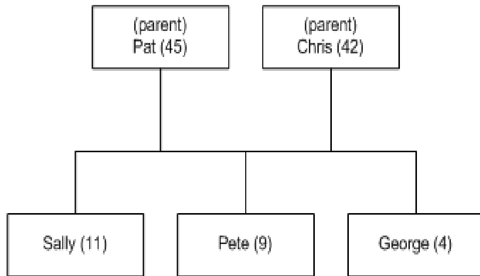
____
____
____
____

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.



☐ 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?
If parents are divorced or separated, how often does your child visit with the other parent?

____

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.

Name of Medication	Dosage and how often	How long child has taken this

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

____

____

☐ Yes ☐ No ☐ I don't know 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:

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".

Medical Conditions	Mother	Father	Sibling	Aunt	Uncle	Cousin	Grandparent	Other
Learning Disability								
Attention Deficit Disorder								
Mental Retardation								
Autism								
Pervasive Developmental Disorder								
Speech and Language Disorder								
Hearing Loss/Deafness								
Tourette or Tic disorder								
Congenital disorder								
Thyroid disease								
Chronic illness (Please list)								
Depression								
Bipolar disorder								
Suicide Attempt								
Anxiety								
Obsessive Compulsive Disorder								
Schizophrenia								
Psychiatric hospitalization								
Alcohol dependency								
Chemical dependency								
Eating disorder								
Obesity/Weight Problem								
Cardiac (Heart) problems								
Other								

☐ 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.

Family Member	Age	Clinic or Facility	Reason for Treatment
____________________	_______	_________________	______________________
____________________	_______	_________________	______________________
____________________	_______	_________________	______________________

Space For Interviewer Notes:

CHILD'S MEDICAL HISTORY

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 diet or nutritional supplements ____

☐ 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:

Diagnosis	Age	Prescribing Physician	Result of Treatment

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.

Diagnosis	Age	Clinician or Facility	Treatment

☐ 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
- ☐ Shows an excessive reaction to noise
- ☐ Failure to react to touch
- ☐ Over reaction to touch
- ☐ Doesn't play make believe games
- ☐ Preoccupied with one particular interest
- ☐ Poor eye contact
- ☐ 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
- ☐ Does not seek or share enjoyment with others
- ☐ Resists comforting by caregivers
- ☐ Shows excessive familiarity with strangers
- ☐ Overly trusting of unfamiliar people
- ☐ Often overly guarded, watchful of others
- ☐ Shows changeable and contradictory responses to others
- ☐ Other ____

Space for Interviewer Notes:

CURRENT BEHAVIOR

☐ Yes ☐ No 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
☐ Persistent avoidance of being alone
☐ Overly high personal standards and expectations
☐ Very self- conscious
☐ Difficulty tolerating new situations or change
☐ Frequently irritable
☐ Gives up easily
☐ Difficulty falling or staying asleep
☐ I don't know
☐ 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

☐ Yes ☐ No Has your child had any of the following difficulties?

☐ Sad, depressed or irritable mood most of the day
☐ Decrease or increase in appetite
☐ Self-destructive thoughts or behavior
☐ Difficulty falling asleep
☐ Low energy/frequently tired
☐ Cries easily or often
☐ Slow moving
☐ Self-critical statements
☐ Diminished pleasure in activities
☐ Sleeps too much
☐ Early morning waking
☐ Unusual thinking or behaviors

☐ Yes ☐ No

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

☐ Yes ☐ No 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)

____

____

☐ Yes ☐ No Does your child have problems with physical or verbal aggression? If yes, describe.

____

____

☐ Yes ☐ No Does your child get along well with others?

☐ Yes ☐ No Does your child display any of these behaviors?

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

☐ Yes ☐ No Does your child show any difficulties with activity level of impulsive behaviors?

☐ Yes ☐ No 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

☐ 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:

Nature of problem (e.g. language delay)	Dates of service/Facility

☐ 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
☐ Other ____

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
☐ I don't know
☐ Facial expressions
☐ Rate of speech

☐ 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.