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DEVELOPMENTAL HISTORY FORM FOR SCHOOL-AGED CHILDREN

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? ❑ No ❑ Yes. If yes, please complete 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 ____

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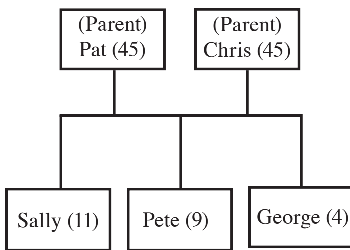
SCHOOL INFORMATION

School Name	Homeroom Teacher	Grade
Address		
Contact Person	Phone	Fax

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?______________________________

CURRENT CONCERNS

Why are you seeking an evaluation?

Does your child have a current diagnosis?

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

Which symptoms or behaviors concern you most at this time?

What are your goals for this assessment?

❑ Yes ❑ No ❑ I Don't Know Does your child have a history of:

❑ Serious trauma of 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?

PREVIOUS EVALUATIONS, TREATMENTS AND HOSPITALIZATIONS

Please list your previous evaluations and treatments in chronological order, including school evaluations, private evaluations and counseling and hospitalizations:

1. Date of Treatment/Evaluation: ______________________________

   Age at Treatment/Evaluation: ______________________________

   Provider Name/Address: ______________________________

   Diagnosis: ______________________________

   Treatment/Recommendations: ______________________________

   Outcome: ______________________________

2. Date of Treatment/Evaluation: ______________________________

   Age at Treatment/Evaluation: ______________________________

   Provider Name/Address: ______________________________

   Diagnosis: ______________________________

   Treatment/Recommendations: ______________________________

   Outcome: ______________________________

3. Date of Treatment/Evaluation: ______________________________

   Age at Treatment/Evaluation: ______________________________

   Provider Name/Address: ______________________________

   Diagnosis: ______________________________

   Treatment/Recommendations: ______________________________

   Outcome: ______________________________

4. Date of Treatment/Evaluation: ______________________________

   Age at Treatment/Evaluation: ______________________________

   Provider Name/Address: ______________________________

   Diagnosis: ______________________________

   Treatment/Recommendations: ______________________________

   Outcome: ______________________________

5. Date of Treatment/Evaluation: ______________________________

   Age at Treatment/Evaluation: ______________________________

   Provider Name/Address: ______________________________

   Diagnosis: ______________________________

   Treatment/Recommendations: ______________________________

   Outcome: ______________________________

Continue on the back if needed.

SYMPTOM CHECKLIST

❑ Yes ❑ No Does your child have any of the following symptoms of worrying?

- ❑ Unrealistic worry
- ❑ Frequently refuses to sleep alone
- ❑ Difficulty tolerating normal errors
- ❑ Excessive need for reassurance
- ❑ Shy or withdrawn
- ❑ Repeated nightmares
- ❑ Worry about separation from those close to him or her
- ❑ Persistent avoidance of being alone
- ❑ Overly high personal standards and expectations
- ❑ Avoidance of situations that make them nervous
- ❑ Excessive worry about health/illness
- ❑ Unrealistic and persistent fears about the health of or harm coming to parents, siblings or others close 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 symptoms related to their mood?

- ❑ 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
- ❑ Overly high personal standards and expectations
- ❑ Diminished pleasure in activities
- ❑ Sleeps too much
- ❑ Early morning waking
- ❑ Unusual thinking or behaviors

❑ Yes ❑ No Has your child had any of the following behavior problems?

- ❑ Won't do what parents or teachers say
- ❑ Often loses temper
- ❑ Hurts animals
- ❑ Problems with police
- ❑ Refuses to obey curfew or other family rules
- ❑ Physically aggressive towards others
- ❑ Damages property
- ❑ Expelled/suspended from school
- ❑ Use of alchohol and/or drugs
- ❑ Vandalism

❑ Yes ❑ No Has your child had any problems related to attention?

- ❑ Difficulty paying attention to things they aren't interested in
- ❑ Organization of time/materials
- ❑ Restless, fidgety—can't sit still
- ❑ Difficulty starting, staying with and finishing homework
- ❑ Acting before thinking
- ❑ Forgetting school materials/homework
- ❑ Remembering what they are supposed to do

❑ 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 changeable and contradictory responses to others
- ❑ Shows excessive familiarity with strangers
- ❑ Overly trusting of unfamiliar people
- ❑ Often overly guarded, watchful of others
- ❑ Other ____

SYMPTOM CHECKLIST--Continued

❑ Yes ❑ No Does your child experience any of the following difficulties with sleep?

❑ Difficulty falling asleep ❑ Waking in the night
❑ Night Terrors ❑ Early morning waking
❑ Nightmares ❑ 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 diculties with eating?

❑ Difficulty sitting at table ❑ Over eats
❑ Poor food choices ❑ Picky Eater
❑ Avoids food due to texture ❑ Odd eating behaviors/habits
❑ Other____

❑ Yes ❑ No Does your child have of the following diculties with elimination?

❑ Daytime wetting ❑ Toilet refusal
❑ Night wetting ❑ Constipation
❑ Soiling ❑ Diarrhea
❑ Other____

❑ Yes ❑ No Does your child frequently complain of physical symptoms not related to medical problems?

❑ Stomach aches ❑ Fatigue
❑ Headaches ❑ Dizziness
❑ Joint aches ❑ Heart Palpitations
❑ Breathing Problems ❑ Tremors/Shakes
❑ Other____

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

❑ Yes ❑ No Has your child had any of the following health problems?

❑ Seizures ❑ Chronic ear infections
❑ Asthma ❑ 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

MEDICAL HISTORY

Primary Physician	Primary Physician Phone
Primary Physician Address	
Referred By	Phone
Address	
Insurance Company	Will your insurance company cover this evaluation? ❑ Yes ❑ No ❑ I don't know

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.

Name of Medication	Dosage & How Often	How Long Has Child Taken?

❑ 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 .

___

___

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FAMILY MEDICAL HISTORY

Please indicate all medical conditions that have occurred in your 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 your 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 Spectrum 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/Chemical dependency								
Eating disorder								
Obesity/Weight Problem								
Other								

❑ Yes ❑ No Has anyone in your 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

DEVELOPMENTAL HISTORY

This child's 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

❑ 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 ______________________________

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________________

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❑ 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.)

____

____

Please describe your child's temperament at the following ages

Infancy (birth–12 months):	❑ Pleasant/happy	❑ Fussy	❑ Colicky	❑ Other ____________
Toddler (12–36 months):	❑ Pleasant/happy	❑ Fussy	❑ Colicky	❑ Other ____________
Preschool (36–60 months):	❑ 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.)

____

____

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.

____

____

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
- ❑ Echoes or repeats the same phrase over and over
- ❑ Repeats the same behavior over and over
- ❑ Doesn't play make believe games
- ❑ Preoccupied with one particular interest
- ❑ Poor eye contact
- ❑ High pain tolerance
- ❑ 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

EDUCATIONAL HISTORY

❑ Yes ❑ No Have any teachers, daycare providers or other caregivers observed your child having difficulty with any of the following?
- ❑ Structured activity
- ❑ Behavior
- ❑ Peer Relationships
- ❑ Group activity
- ❑ Attention
- ❑ Transitions

❑ Yes ❑ No Do you have any specific concerns regarding your child's learning progress?
- ❑ Teacher relationships
- ❑ Behavior
- ❑ Social skills
- ❑ Transitions
- ❑ Group Activities
- ❑ Speech and language skills

❑ Yes ❑ No Has your child had a school evaluation? If yes, what is the date of the last evaluation? When is the next?

____

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

- ❑ Early Childhood Special Education under the category of: ______________________________
- ❑ 504 Plan under the category of: ______________________________
- ❑ IEP under the category of: ______________________________

COMMUNITY SERVICES

❑ Yes ❑ No Have you or your child been involved with any of the following resources?
- ❑ PCA care
- ❑ ARC
- ❑ Respite care
- ❑ PACER
- ❑ County social worker
- ❑ Other ______________________________
- ❑ Foster care
- ❑ Developmental disorder social worker

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 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 or multiple part directions ❑ Understanding questions
- ❑ Understanding vocabulary ❑ Understanding age appropriate jokes
- ❑ Understanding idioms (such as "You're in a pickle")

❑ Yes ❑ No Does your child have any problems with expressive language?

- ❑ Grammar/sentence structure ❑ Initiating or maintaining conversation
- ❑ Adjusting to a listener's needs ❑ Using appropriate vocabulary
- ❑ Sequencing a story from start to finish
- ❑ 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?

- ❑ 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 ❑ Often misunderstands what was said
- ❑ Distracted by background noise ❑ Answers questions incorrectly
- ❑ Says "what?" a lot ❑ Complains of dizziness, rining in ears or balance problems
- ❑ Difficulty locating source of sounds

❑ Yes ❑ No Does your child have any difficulty using or understanding non-verbal cues?

- ❑ Body language ❑ Facial expressions
- ❑ Tone of voice ❑ 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.