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Developmental History

Please complete the following questionnaire to give me a general understanding of your child's developmental history.

Child's name: _____ Birth date: _____ Age: _____
Name of the parent/guardian: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____ Today's date: _____
Home Phone: () _____ - _____ Cell Phone: () _____ - _____ e-mail: _____
Emergency Contact's name: _____ Phone: () _____ - _____
Person completing this form: _____ Relationship to child: _____
Child's Birthplace: _____

What are your primary concerns for your child?

Who referred you to me? _____

Family History:

- Child is living with:
 Both parents Mother Father Grandparent(s)
 Mother & Stepfather Father & Stepmother Legal Guardian
 Other: _____
- Is the child adopted:
 Yes No Child's age at adoption: _____
- Status of parents' marriage:
 Married Separated Divorced Widowed Single
How long married? _____ How long divorced? _____ Child's age at divorce: _____
- Father's Name: _____ Age: _____ Education: _____
Employed: _____ Work phone: _____
Type of work: _____
- Mother's Name: _____ Age: _____ Education: _____
Employed: _____ Work phone: _____
Type of work: _____

6. List the people who live at home:

Name:	Age:	Relationship to child:	Occupation:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Please provide any information about your child's immediate/extended family that might help us understand the child's needs (e.g., medical, developmental, behavioral, educational, emotional, or psychological):

Educational History:

Current grade: _____ Name of School: _____
Phone Number: _____

Teacher's Name: _____

Type of school: Public Private Special

How does the school describe your child's classroom behavior? _____

What does your child do best at school? _____

Is he/she involved in extracurricular activities? Please list _____

Do you feel your child is learning up to his or her potential? Yes No

If no, please indicate the academics areas that are underdeveloped:

Mathematics: Problems with acquisition of mathematical facts Careless errors
 Difficulty performing simple arithmetic (e.g., addition, subtraction, division)
 Difficulty understanding word-problems Other: _____

Reading: Difficulty matching letter sounds to written symbols
 Difficulty pronouncing words (especially long ones)
 Reading is "choppy" or non-fluent
 Difficulty with reading comprehension Other: _____

Writing: Poor pencil grip Letters too big Inconsistent spacing / inconsistent handwriting
 Difficulty expressing ideas in writing Poor spelling

Language: Difficulty finding words to name objects Takes a long time to get a thought across
 Difficulties understanding or following directions even when paying attention
 Other: _____

Please check any other concerns or problem your child has in school:

<input type="checkbox"/> Does not do homework	<input type="checkbox"/> Excessive time to complete assignments	<input type="checkbox"/> Distracted
<input type="checkbox"/> Poor handwriting	<input type="checkbox"/> Forgets assignments	<input type="checkbox"/> Test Anxiety
<input type="checkbox"/> Does not remain seated	<input type="checkbox"/> Starts but does not finish homework	<input type="checkbox"/> Noncompliant in class
<input type="checkbox"/> Incomplete classroom work	<input type="checkbox"/> Excessive talking	<input type="checkbox"/> Fails to check homework
<input type="checkbox"/> Messy/disorganized	<input type="checkbox"/> Poor attention in class	<input type="checkbox"/> Makes careless errors

Has your child been retained a grade? Yes No. If yes, which grade? _____
 Did your child attend preschool or daycare? Yes No
 Were there any early concerns regarding learning or behavior? Yes No
 Has the child been placed in special education programs currently or in the past? Yes No

Does your child have:

1. Learning disability (LD): Yes No. Subjects: _____
2. Language disorder: Yes No. Type: _____
3. Tutoring: Yes No. Where: School Other: _____

Is your child receiving special education/ 504 / Other Health Impaired (OHI) services? Yes No

Birth and Developmental History:

Pregnancy:

Length of pregnancy: _____ Illness or complications while pregnant? Yes No

If yes, please explain: _____

Medications used **during** the pregnancy: _____

Substances used **during** the pregnancy:

- Cigarettes How many? ____ How often? (day/week): _____
- Alcohol How many drinks? ____ How often?(day/week/month): _____
- Drugs Please describe type and frequency of use: _____

Labor and Delivery:

Was your child's birth normal? Yes No

Were there any concerns at birth related to lack of oxygen (e.g., born "blue"?): Yes No

Perinatal History:

Birth weight: _____ Length: _____

Did mother or baby stay in Special or Intensive Care? Yes No

Please describe any problems: _____

Infancy and Early Childhood:

Please rate your child as an infant on the following behaviors. Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	<input type="checkbox"/> Tantrums <input type="checkbox"/> head-banging
Cautious and careful	1	2	3	4	5	<input type="checkbox"/> Accident Prone <input type="checkbox"/> Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with other people

Please list any other problems or comments regarding infancy or early childhood development: _____

Please list (in months) the ages your child met these developmental milestones:

Sat on own: _____ Stood up holding onto furniture: _____ Walked alone: _____

Any concerns with your child's *gross* motor development (e.g., running, skipping, jumping): _____

Fed self with spoon: _____ scribbled: _____ tied shoes: _____

Any concerns with your child's *fine* motor development (e.g., writing, buttoning, zipping): _____

Used single words: _____ Used 2+ word-sentences: _____ described a thought: _____

Any speech hearing or language difficulties? Yes No

Has your child received speech therapy? Yes No

Potty trained/day: _____ Potty trained/night: _____

Overall rate of development: Slow Normal Fast

Medical History:

Pediatrician's Name: _____ Phone Number: _____

Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? Yes No

If yes, please describe condition/injury, treatment, any surgery, how long, and where.

If the child had a head injury: Did s/he lose consciousness? Yes No How long? _____

Has your child been diagnosed with a chronic health condition? Yes No

If yes, please describe: _____

Does your child take any medication on a regular basis? Yes No

If yes, please list the name and dosage: _____

Behavioral and Mental Health History:

1. Please describe any behaviors that are particularly concerning to you or others: _____

2. Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments. _____

3. Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? Yes No

If yes, please give the name of previous therapist: _____

May I contact this provider? Yes No. If yes, please provide phone number: _____

4. Has the child received previous educational or neuropsychological testing? Yes No
 If yes, please list the month and year in which testing was completed:

5. Please circle all traits that apply to the child **NOW**:

- | | | | | | |
|-------------|-------------|---------------|-----------|-------------------------|------------|
| sad | Happy | leader | follower | moody | friendly |
| overactive | independent | dependent | sensitive | affectionate | fearful |
| cooperative | tantrums | lethargic | loner | sleep problems | misbehaves |
| quiet | defiant | even-tempered | | difficult to discipline | |

6. Interactions with peers: No friends Few Friends Loses friends
 Trouble making new friends Mean, aggressive Too shy or too timid
 Bossy, controlling Risky behaviors

Has your child experienced any of the following:

- Being teased or bullied Teasing/bullying others Peer rejection Popularity with peers

7. Has your child or any of your family members struggled with any of the following problems? Place checkmark in all that apply:

Condition	Child Current	Child Past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety, Excessive worries						
Panic Attacks						
Obsessions/Compulsions						
Tics: vocal / motor						
Headaches						
Suicidal Thoughts						
Attempted Suicide						
Learning Disability						
ADHD						
Problems with anger						
Problems with Assertiveness						
Opposition or Defiance						
Problems with the Law						
Schizophrenia/Psychosis						
Nervous Breakdown						
Heavy Alcohol Use						
Drug Use						
Eating Disorder						
Abuse/Neglect						
Other						

Please list any other areas of concern or information you feel I need to know in the area below: