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Developmental History Form

_____ _____
Child's Name Date of Birth

_____
Address Phone

_____ _____
School Grade

Parent's Information		Parent's Information	
Name		Name	
Occupation		Occupation	
Education		Education	

This is your ☐Biological ☐Adopted ☐Foster child

Parents are ☐Unmarried ☐Married ☐Separated ☐Divorced ☐Widowed/Widower

Are there significant family or marital conflicts: ☐no ☐yes_____
_____

Name of the child's legal guardian(s): _____

Please list all children/adults who reside with the child.

Full Name	Sex	Date of Birth	Age	Grade	Relationship

Please list all other immediate family members who do not reside with the child.

Full Name	Sex	Date of Birth	Age	Grade	Relationship

Reason(s) you are requesting this evaluation: _____
_____
_____
_____

History of Treatment: Therapies/Evaluations

	Psychology/Psychiatry	Occupational Therapy	Physical Therapy	Speech/Language
Treatment				
Date(s)				
Provider				
Evaluation				
Date(s)				
Provider				

Does your child receive special services at school: ☐no ☐yes; ☐504 or ☐IEP; Exceptionality _____

Current medical diagnoses: ☐no ☐yes_____

Current psychiatric diagnoses: ☐no ☐yes_____

Current speech diagnoses: ☐no ☐yes _____

Pregnancy and Birth History

1. Age of mother at delivery? _____
2. Were there problems becoming pregnant? ☐Yes ☐No
3. Did mother receive regular prenatal care? ☐Yes ☐No
4. Mother's health during pregnancy: (Check any that apply)
   ☐Toxemia ☐RH incompatibility ☐High blood pressure ☐fevers ☐Diabetes
   ☐Epilepsy ☐Injuries ☐ Medications _____
   ☐Drank alcohol ☐Smoked cigarettes ☐Used recreational drugs
5. Delivery was ☐Full term ☐Premature (_____ weeks gestation)
   Delivery was ☐Vaginal ☐Cesarean
6. Birth weight ____lb ___oz
7. Condition at Birth: ☐ok ☐problems:
   ☐jaundice ☐had infection ☐trouble breathing ☐trouble sucking
   ☐ birth defects ☐birth injuries ☐needed surgery ☐needed intensive care
   ☐in hospital more than 5 days ☐anemic ☐other problems _____

Developmental History

1. Temperament: ☐cuddly ☐fussy ☐social ☐quiet ☐ difficult to soothe ☐slow to adjust to change
2. Motor: Age Sat alone _____Crawled _____Walked alone_____
3. Language: Age Spoke first word_____ Put 2-words together _____ Put 3-words together _____

4. Toilet Training: Age training was initiated Bowel _____ Bladder_____
   Age training was completed Bowel _____ Bladder_____

5. Eating difficulties? ☐no ☐yes_____

6. Sleeping difficulties? ☐no ☐yes_____

7. Problems with separation from parent(s)? ☐no ☐yes_____

8. Behavior Problems? ☐no ☐yes_____

9. Did your child receive Birth-To-Three Services? ☐no ☐yes: ☐OT ☐PT ☐Speech

Medical/Health

1. Physician Name:_____ Phone Number: _____
   Address: _____

2. Is your pediatrician aware of this referral? ☐no ☐yes

3. Has vision been checked(date)?_____ any problems: _____

4. Has hearing been checked(date)?_____ any problems: _____

5. List all serious illnesses/injuries/hospitalizations/surgeries

   Date Incident (explain)

   _____ _____

   _____ _____

   _____ _____

   _____ _____

6. Medication Please list all current and past medications:

Type	Dose	Start Date	End Date

7. Provide full name of prescribing physician here_____ Phone Number _____

8. Is there a history of any of the following conditions (please circle yes or no):

			Additional Information
Febrile seizure	Yes	No	
Epilepsy	Yes	No	
Lead poisoning/toxic ingestion	Yes	No	
Asthma or allergies	Yes	No	
Head injury	Yes	No	

Loss of consciousness	Yes	No	
Abdominal pains/vomiting When do they occur?	Yes	No	
Headaches When do they occur?	Yes	No	
Frequent ear infections	Yes	No	
Sleeping difficulties	Yes	No	
Eating difficulties	Yes	No	
Tics/twitching	Yes	No	

Education

1. Days absent in past year: _____
2. Skipped or repeated a grade: ☐no ☐yes _____
3. Teacher report problems in: ☐ reading ☐spelling ☐math☐writing ☐behavior
   ☐attention/concentration ☐social adjustment

Please explain:_____

_____

4. **Grade:** **Academic Problems? (please explain)**

Nursery _____
Kindergarten _____
First _____
Second _____
Third _____
Fourth _____
Fifth _____
Sixth _____
Seventh _____
Eighth _____
Ninth _____
Tenth _____
Eleventh _____
Twelfth _____

Social

☐no ☐yes: My child plays with children his/her own age.
☐no ☐yes: My child engages in normal imaginative or pretend play.
☐no ☐yes: My child's play generally revolves around one particular theme with minimal variation.
☐no ☐yes: My child is willing to let others join in games and play situations.
☐no ☐yes: My child engages in parallel play (plays besides another but does not engage them).
☐no ☐yes: My child engages in cooperative play.
☐no ☐yes: My child gets along well with other children.

Behavior

Please mark any boxes that describe your child:

☐Poor eye contact	☐Unusual vocal patterns	☐Aggressive	☐Impulsive	☐Sensitive
☐Sad	☐Tense	☐Inattentive	☐Easily frustrated	☐Shy
☐Temper tantrum	☐Uses alcohol/drugs	☐Nail biting	☐Head bangs	☐Happy
☐Distractible	☐Friendly	☐Helpful	☐Immature	☐Unhappy
☐Often Tearful	☐Disorganized	☐Dependent	☐Self-injurious behaviors	
☐Trouble with the police		☐Repetitive/stereotyped movements		☐ Nightmares

Sensory-Motor

1. Hand preference: ☐ Right ☐ Left ☐ None
2. Does your child:

Dislike certain food textures	☐no ☐yes_____
Chew on non-food items (shirt, pencil, etc.)	☐no ☐yes_____
Dislike touching certain textures (paste, etc.)	☐no ☐yes_____
Dislike getting dirty	☐no ☐yes_____
Dislike being touched	☐no ☐yes_____
Appear clumsy or off-balance	☐no ☐yes_____
Have trouble with eye-hand coordination	☐no ☐yes_____
Have an unusual posture/gait	☐no ☐yes_____
Have difficulty with handwriting or drawing	☐no ☐yes_____

Family Information

1. Overall health: Parent _____ Parent _____
2. Please specify if any of the following events occurred during the previous 2 years:

deaths_____

move_____

job transfer_____

accidents/serious illness_____

3. Please provide a family history. Include the child's parents, grandparents, siblings, aunts, uncles, and cousins. ***Please note the relationship to child***:

Is there any history of:	**Biological Mother's Side**	**Biological Father's Side**
learning problems?		
reading problems?		
attention problems?		
stuttering?		
epilepsy or seizures?		
other neurologic disorders?		
diabetes?		
genetic or inherited disorders?		
other serious illnesses/health problems?		
emotional disorders?		
received/is receiving psychiatric treatment?		
hospitalized for an emotional problem?		
drug/alcohol addiction/ abuse?		
attempted/committed suicide?		
with violent behavior?		

_____ _____

Completed By Completed By

_____ _____

Relationship to child Relationship to child

_____ _____

Date Date