

Developmental History Form

The following questions are asked so that I can best understand your child. Please fill out this questionnaire before your first appointment. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary. If there are any questions you don't understand, they can be filled out with my help when I review the history with you. Please star (*) such questions.

Demographic Information

Child's Name: _____ Birth Date: _____ Age: _____ Grade: _____

Parent(s) Name: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Parent's Cell: _____

Child's Doctor: _____ Phone: _____

What are the problems that caused you to seek help for this child?

Family History

Child is living with: Both parents Mother Father Mother & Stepfather Father & Stepmother
 Legal Guardian Other (please specify)

Is the child adopted? Yes No If yes, with which parent(s) (if any) does the child live? natural adoptive
Child's age at adoption: _____

Status of parents' marriage: Married How long married? _____

Separated Divorced How long divorced? _____ Child's age at divorce: _____

Widowed Single

Birth Mother

Birth Father

Age: _____

Highest Grade Completed: _____

Diploma/Degree: _____

Occupation: _____

Please describe any special education or tutoring:

Please describe any grades repeated or subjects failed:

Birth Mother

Birth Father

Please describe any learning difficulty, and subject and grade level at which it occurred:

Please describe any behavior problems and treatment received:

Any Attention-Deficit Disorder or Hyperactivity? Please describe treatment:

Adoptive Mother/Stepmother/Other

(circle one)

Age: _____

Highest Grade Completed: _____

Occupation: _____

Adoptive Father/Stepfather/Other

(circle one)

Other Children (including step-siblings and half-siblings)

Name	Sex	Age	In home?	School/behavioral/health problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Biological Extended Family

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with inattentiveness or hyperactivity; epilepsy; seizures; migraines; alcoholism or substance abuse; psychological, emotional or personality difficulty; learning problems or developmental disabilities; and/or a "nervous" or neurological disorder, etc.?

Yes No If yes, please list relationship to child, disorder, and any treatment received:

Maternal (mother's side)

Paternal (father's side)

Please provide any other information about your child's extended family that might help me understand your child's needs (medical, developmental, behavioral, educational, emotional or psychological).

Birth and Developmental History

Pregnancy

Length in months: _____

Any illnesses or complications while pregnant? Yes No If yes, please explain: _____

Medications taken by the mother during pregnancy? _____

Substances used during pregnancy: _____

Cigarettes How many? _____ per (day week)

Alcohol How many? _____ per (day week month)

Drugs Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable):

Was the father taking any medications or drugs at time of conception? Yes No If so, what?

How many pregnancies and/or miscarriages has the mother had? _____

Labor and Delivery

Was the birth of the child "normal"? Yes No If so, please explain:

Do you think the child's problems might be related to pregnancy, labor, or delivery? Yes No If so, explain:

Perinatal History

Birth weight _____ Length _____ APGAR scores _____

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

Please describe any problems: _____

Infancy and Early Childhood

Please rate the child 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. If there are two behaviors listed (e.g., tantrums and head banging), please check the one that was present.

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 people

Other problems or comments regarding infancy or early childhood development: _____

Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship? Yes No If yes, please explain: _____

Please describe the child as an infant (temperament, sleeping, eating patterns, etc.): _____

Ages at Milestones

Gross Motor Skill	Age	Language Skill	Age
Crawled	_____	used single words	_____
walked alone	_____	used sentences (2+ words)	_____
ran well	_____	described activity	_____
Fine Motor Skill	Age	Social/Adaptive Skill	Age
fed self with spoon	_____	potty trained / day	_____
scribbled	_____	potty trained / night	_____
tied shoe	_____		

Rate of development overall: Slow Normal Fast

Medical History

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, when, how long:

If the child had a head injury, did he or she lose consciousness? Yes No

If yes, how long? _____

Was he or she comatose? Yes No If yes, how long? _____

Do you see the child as being hyperactive? inattentive? a behavior problem?

Does the child seem to be able to control his or her behavior or attention?

Yes No If no, please explain: _____

Has the child ever been diagnosed by a psychologist, physician, or other professional as having ADHD (Attention-Deficit / Hyperactivity Disorder)? Yes No

If yes, when? _____

What treatment has the child had for ADHD (other than medications)? _____

What medication(s) has the child received for ADHD (include dosage and times)? _____

Please describe any other handicapping conditions or special health considerations and their treatments:

Date of last hearing test: _____ Were the results normal? Yes No

If no, please explain:

Date of last vision test: _____ Does the child wear glasses? contacts?

Why? _____

Please list medications currently being taken by the child, including nonprescription medications (with dosage and times):

The child's current health is: Poor Fair Good Excellent

Behavioral and Mental Health History

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

When did you first notice the problem behavior and how long has the behavior been going on:

Where does the problem behavior occur and are there environments or situations that make the behavior worse and/or better:

Please describe any significant or stressful life events that your child has been experiencing:

	No	Yes	If yes, please describe:
A recent move or change in school			
Abuse or neglect			
Bullied or ignored by peers			
Academic difficulties			
Weight control issues			
Sexual orientation concerns			
Self-injury			
Death or Illness of a loved one or pet			
Family conflict			
Separation or Divorce			
Other			

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother	
Biological Father	
Step-parents	
Legal guardians	

Siblings	
Extended family	
Friends	
Classmates	

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 list any past and current treatments, including type of counseling, person counseled, name of counselor, and length of treatment: _____

Present Personality and Behavior

Please circle all traits that apply to the child now:

- sad happy leader follower moody friendly quiet overactive independent
- dependent sensitive affectionate fearful cooperative tantrums lethargic
- too responsible trouble sleeping hard to discipline even-tempered prefers to be alone

Educational History

Did the child attend preschool or daycare? If so, list location, type of program, number of days per week, age when started, and progress: _____

Current grade in school: _____

List previous schools and grades attended at each: _____

Briefly describe the child's performance and any concerns in each grade:

Kindergarten: _____

1st grade: _____

2nd grade: _____

3rd grade: _____

4th grade: _____

5th grade: _____

6th grade: _____
7th grade: _____
8th grade: _____
9th grade: _____
10th grade: _____
11th grade: _____
12th grade: _____

Please check off all items that your child is presently struggling with at school this year:

- | | |
|--|--|
| <input type="checkbox"/> Low Test/Quiz Grades | <input type="checkbox"/> Not Completing Homework |
| <input type="checkbox"/> Organizational Issues | <input type="checkbox"/> Separation Issues |
| <input type="checkbox"/> Poor Study Skills | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Social Skill Issues | <input type="checkbox"/> Attentional Issues |
| <input type="checkbox"/> Low Motivation | <input type="checkbox"/> Low Self-Esteem |
| <input type="checkbox"/> Increased Frustration | <input type="checkbox"/> Emotional Issues |

Has the child been placed in special education programs currently or in the past? Yes No If yes, describe:

Category: _____

Learning Disability (LD): _____
(subjects)

Language Disorder: _____
(type)

Tutoring: _____
(subjects)

Additional Information

Please attach results of any previous testing.

Please add any additional comments you think might be helpful (use the back if necessary).

Please bring copies of your child's grades, standardized test scores, any evaluations, and special education paperwork (if applicable).

Signature: _____
Individual completing form, relationship to child

Date: _____