

DEVELOPMENTAL HISTORY

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

Person(s) Completing This Form: _____ Today's Date: _____

Relation to Child: _____ Language Spoken in Your Home: _____

Birth Weight: ____ pounds ____ ounces Length of Pregnancy: ____ weeks Type of Delivery: _____

Please describe any complications during pregnancy or birth: _____

Please describe your child's health during and after delivery: _____

Was your child breast-fed? Yes No If so, when weaned? _____

Was your child bottle-fed? Yes No If so, when weaned? _____

Please indicate the approximate age your child achieved the following developmental milestones:

Sat Up Alone _____ Crawled _____ Walked Alone _____
Spoke First Words _____ Spoke in Sentences _____ Toilet Trained _____

Please check the items that accurately describe your child during infancy:

_____ No Feeding Problems
_____ Experienced Feeding Difficulties (please describe) _____
_____ Slept Well
_____ Sleep Difficulties (please describe) _____

Please check the items that best describe your child as an infant:

_____ Alert and Responsive	_____ Lethargic
_____ Irritable/Fussy	_____ Quiet/Complacent
_____ Overactive	_____ Rigid and Withdrawn
_____ Frequently Smiled	_____ Frequently Cried
_____ Difficult to Comfort	_____ Easily Adapted to New Situations

During early childhood, please indicate if your child displayed any of the following behaviors:

_____ Eating Difficulties	_____ Sleep Difficulties	_____ Temper Tantrums
_____ Separation Anxiety	_____ Unusual Fears/Anxieties	_____ Nightmares
_____ Excessive Crying	_____ Thumb Sucking	_____ Social Skill Issues

Do you have concerns about your child's development in any of the following areas?

_____ Speech/Language	_____ Fine Motor Skills	_____ Gross Motor Skills	_____ Cognitive
_____ Social Skills	_____ Sensory	_____ Behavior	_____ Emotional

HEALTH AND MEDICAL INFORMATION

Date of your child's last medical examination: _____

Please indicate if your child has experienced or has been diagnosed with any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Vision Difficulties |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Sustained High Fevers | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Other (please explain) _____ |

Has your child had any serious illnesses, surgeries, accidents, or injuries? Yes No

If so, please explain: _____

Does your child suffer from any type of environmental or food allergies? Yes No

If so, please describe: _____

Is your child currently taking any medication? Yes No

If so, please provide information regarding name of medication and dosages: _____

Name of physician prescribing the above medications: _____

SOCIAL/EMOTIONAL INFORMATION

Please list activities/hobbies that your child enjoys: _____

Which of the following words best describes your child?

- | | | |
|---|----|---|
| <input type="checkbox"/> Leader | or | <input type="checkbox"/> Follower |
| <input type="checkbox"/> Independent | or | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Friendly | or | <input type="checkbox"/> Disagreeable |
| <input type="checkbox"/> Attentive | or | <input type="checkbox"/> Inattentive |
| <input type="checkbox"/> Follows Directions | or | <input type="checkbox"/> Does Not Follow Directions |
| <input type="checkbox"/> Confident | or | <input type="checkbox"/> Shy/Insecure |

Please list any sports teams, clubs, and activities your child participates in at school or in the community: _____

Has your child received counseling? Yes No If so, please explain _____

Has your child ever had a psychological or psychiatric evaluation? Yes No If so, please explain _____

What are your child's strengths? _____

What are your child's challenges? _____

EDUCATIONAL INFORMATION

Did your child attend daycare prior to preschool? Yes No If so, at what age? _____

Did your child attend full-time or part-time? _____ Any issues/concerns with the daycare setting? Yes No

If so, please describe: _____

List all schools your child has attended to date (including preschool):

Name of School	Age Attended	Grade(s)	Location

Has your child ever repeated a grade? Yes No If so, please specify: _____

Is your child receiving special education services (i.e. speech/language, occupational therapy, physical therapy, etc.)? Yes No

If so, please specify: _____

Does your child have a 504 Plan? Yes No If so, please explain: _____

Is your child receiving accelerated and enriched instruction (i.e. gifted and talented program)? Yes No

If so, please specify: _____

Does your child receive tutoring support? Yes No If so, please explain: _____

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

Is there a family history of learning, attentional, behavioral, and/or social/emotional difficulties? Yes No

If so, please explain: _____

Are there presently any family stressors (i.e. financial issues, illness, separation/divorce, domestic violence, substance abuse, etc.)?

Yes No If so, please explain: _____

Thank you for taking the time to complete this form. All Information will be kept strictly **confidential**.