# DEVELOPMENTAL HISTORY

**DIRECTIONS:** To the best of your ability, please answer all of the questions, as all items provide important information which will be essential in your child's evaluation. If you do not understand any item, please make a note next to the item and we can discuss it further.

Child's Name: _____ Date: _____

Address: _____ ○ Male ○ Female

Phone: _____ DOB: _____ Age: _____

## Referral Information

Who referred you? Name: _____ Phone: _____

How old was your child when you first wondered if there might be something different with his/her development? 0 years, 0 months

What are your concerns about your child's behavior and/or development now? (Please be specific) _____

## Parents

Parent/Guardian: _____
Address: _____
Home Phone: _____ Mobile: _____ Email: _____
Occupation: _____ Employer: _____
Highest Grade Completed: _____

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## Child Care

*If primary caregivers work outside the home, please provide the following information.*

Who cares for this child when caregivers are gone? _____

How many hours per day and per week is this child in a child-care setting? _____

## Family History

Has this child ever experienced any parental separations, divorces, death, or other trauma? ○ No ○ Yes

If yes, when? _____ How old was your child at the time? _____

Please describe the circumstances: _____

If parents are separated or divorced, please explain the custody arrangements: _____

**Brothers/Sisters**

*Please list all brothers and sisters, their relationship to this child, any developmental disabilities, and if they live at home.*

| Name | Age | Sex | Biological/adoptive? | Developmental Difficulties | Live at home? |
|---|---|---|---|---|---|
| _____ | _____ | Female | Biological | _____ | yes |
| _____ | _____ | Female | Biological | _____ | yes |
| _____ | _____ | Female | Biological | _____ | yes |
| _____ | _____ | Female | Biological | _____ | yes |

**Household**

Is there anyone else, not previously listed, living in the home? yes

If yes, please list name, age, and relationship to the child: _____

**Family Relations**

How would describe your child's relationship with other family members:? (please note if more responsive to some than others)

Mother: _____

Father: _____

Siblings:_____

Grandparents: _____

Other: _____

**Pregnancy**

Was the mother under a doctor's care? yes

*Check any of the following complications that occurred during the pregnancy.*

☐ Difficulty in conception ☐ Toxemia ☐ Abnormal weight gain/loss

☐ Pregnancy induced medical conditions: Describe: _____

☐ Emotional difficulties: Describe: _____

☐ Maternal injury: Describe: _____

☐ Hospitalization/s during pregnancy: Reason: _____

☐ Alcohol used during pregnancy: Frequency _____

☐ Cigarettes used during pregnancy: Frequency _____

☐ Medications or drugs used during pregnancy:

| Name | Used For | Dosage | How long taken? | Prescription |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | yes |
| _____ | _____ | _____ | _____ | yes |
| _____ | _____ | _____ | _____ | yes |

**Birth**

Biological mother's age at birth of this child? _____ Length of pregnancy: _____ wks Birth weight: _____lbs _____oz

Child's condition at birth: _____

Mother's condition at birth _____

Delivery Method used _____

Delivery complications: _____

Medical difficulties post birth? _____

Length of stay in hospital Mother: _____ days Child: _____ days

**Early Development**

Any difficulties establishing regular feeding patterns? ☐ No ☐ Yes (describe): _____
Any difficulties establishing regular sleeping patterns? ☐ No ☐ Yes (describe): _____

At what age did your child do the following?:

Sit alone? _____ months

Crawl? _____ months

Walk without holding on? _____ months

Understand first words? _____ months

First used words meaningfully (other than *Mama* or *Dada*)? _____ months

First words were: _____, _____, _____

First said meaningful 2- or 3-word phrases:? _____ months

Phrases including verbs:_____ months

Was there ever a time that s/he stopped speaking for some months after having learned to talk? ☐ No ☐ Yes

If yes, explain: _____

Has there ever been a period when this child seemed to lose skills or abilities he/she had already attained? ? ☐ No ☐ Yes

If yes, explain: _____

How would you describe your child's personality during the following periods:

0-6 months _____

6-12 months _____

12-18 months _____

18-24 months _____

24-36 months _____

36-48 months _____

48-60 months _____

Did you have any concerns about 'connecting with' or bonding with your child during his/her early years? ☐ No ☐ Yes
If yes, describe: _____

Sleep Patterns

Is your child a good sleeper? ☐ No ☐ Yes How many hours a day (total) does your child sleep? _____

Does your child nap? ☐ No ☐ Yes If yes, how long does your child nap? _____

Does your child nap every day? ☐ No ☐ Yes Does your child nap at the same time every day? ☐ No ☐ Yes

Does your child sleep through the night? ☐ No ☐ Yes If yes, what time does your child go to bed at night? _____

How long does it take your child to fall asleep once in bed? _____ Where does your child sleep at night? _____

Does your child share a room with another child/adult? ☐ No ☐ Yes Is your child a restless sleeper? ? ☐ No ☐ Yes

Toilet Training

Is your child toilet trained? ☐ No ☐ Yes If not, is your child showing any interest in toilet training? ☐ No ☐ Yes

Are you concerned about problems in any of the following areas? If yes, please describe.

| | | | |
|---|---|---|---|
| Speech and language | ☐ No | ☐ Yes | _____ |
| Motor skills | ☐ No | ☐ Yes | _____ |
| Sensory | ☐ No | ☐ Yes | _____ |
| Eating | ☐ No | ☐ Yes | _____ |
| Temper Tantrums | ☐ No | ☐ Yes | _____ |
| Sleeping too little | ☐ No | ☐ Yes | _____ |
| Separating from you | ☐ No | ☐ Yes | _____ |
| Excessive crying | ☐ No | ☐ Yes | _____ |
| Excessive fears | ☐ No | ☐ Yes | _____ |

## Medical History

### Childhood Illnesses/Injuries

*Please describe any serious illnesses or operations and when they occurred :* _____

Has this child ever been on long-term medication (more than 6 months)? ☐ No ☐ Yes

If yes, what type of medication? _____ What did it treat? _____

*Please indicate whether this child currently has any of the following problems. If yes, describe how often.*

**Respiratory**

| | | | |
|---|---|---|---|
| Frequent colds | ☐ No | ☐ Yes | _____ |
| Chronic cough | ☐ No | ☐ Yes | _____ |
| Asthma | ☐ No | ☐ Yes | _____ |
| Sinus Condition | ☐ No | ☐ Yes | _____ |

**Gastrointestinal**

| | | | |
|---|---|---|---|
| Reflux | ☐ No | ☐ Yes | _____ |
| Excessive vomiting | ☐ No | ☐ Yes | _____ |
| Frequent diarrhea | ☐ No | ☐ Yes | _____ |
| Constipation | ☐ No | ☐ Yes | _____ |

Stomach pain ☐ No ☐ Yes _____

**Musculoskeletal**

Clumsy walk ☐ No ☐ Yes _____

Walks on toes ☐ No ☐ Yes _____

Other muscle problems ☐ No ☐ Yes _____

**Neurological**

Seizures ☐ No ☐ Yes _____

Accident prone ☐ No ☐ Yes _____

Grinds teeth ☐ No ☐ Yes _____

Has tics/twitches ☐ No ☐ Yes _____

Bangs head ☐ No ☐ Yes _____

Rocks back and forth ☐ No ☐ Yes _____

**Hearing**

Ear infections ☐ No ☐ Yes _____

Hearing problems ☐ No ☐ Yes _____

Ear tubes ☐ No ☐ Yes _____

Date of most recent hearing test _____ Results _____

**Vision**

Vision problems ☐ No ☐ Yes _____

Wears glasses ☐ No ☐ Yes _____

Wears patch ☐ No ☐ Yes _____

Date of most recent vision exam _____ Results _____

**Medical Care**

Child's physician:_____ Practice Name: _____

Address: _____ Telephone: _____

Current height: _____ Current weight: _____

Current head circumference: _____

**Eating**

Have you ever had concerns about your child's nutritional intake and/or growth? ☐ No ☐ Yes

Please describe: _____

Is your child a "picky" eater (eating only a few foods, only certain textures of food, etc)? ☐ No ☐ Yes

Describe your child's current diet, including liquid intake and times of day that he/she eats and drinks. _____

**Previous Assessments and Intervention:**

Has your child ever had behavior or play therapy, behavior therapy, psychological/developmental testing? ☐ No ☐ Yes

Provider's name: _____ Company: _____

Telephone: _____ Dates of therapy/eval: _____ to _____

Reason: _____

Has this child ever had a neurological exam? ☐ No ☐ Yes

Provider's name: _____ Company: _____

Telephone: _____ Date of exam: _____

Reason for exam: _____

Has this child ever had speech and language therapy? ☐ No ☐ Yes

Provider's name: _____ Company: _____

Telephone: _____ Dates of therapy: _____ to _____

Reason: _____

Has this child ever had occupational therapy? ☐ No ☐ Yes

Provider's name: _____ Company: _____

Telephone: _____ Dates of therapy: _____ to _____

Reason: _____

Has this child ever had physical therapy? ☐ No ☐ Yes

Provider's name: _____ Company: _____

Telephone: _____ Dates of therapy: _____ to _____

Reason: _____

**Family Health**

Have any family members had any of the following? *If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.*

☐ Autism _____ ☐ Asperger's Syndrome _____

☐ Other developmental disorder (specify) _____

☐ Behavior disorder _____ ☐ Trouble with the law _____

☐ Nervousness _____ ☐ Emotional disturbance _____

☐ Anxiety _____ ☐ Depression _____

☐ Bipolar Disorder or "Manic-Depression" _____

☐ Other mental illness _____

☐ Alcohol/drug abuse _____ ☐ Reading problem _____

☐ Other learning disability _____ ☐ Speech or language problen _____

Has anyone in the family ever been in special education? ☐ No ☐ Yes

If yes, which family member? _____ What type of class? _____

**Social Functioning**

*Please indicate how this child relates to other children.*

Has problems relating to, or playing with, other children ☐ No ☐ Yes

If yes, describe: _____

Fights frequently with playmates ☐ No ☐ Yes

Prefers playing with younger children ☐ No ☐ Yes

Prefers playing with older children ☐ No ☐ Yes

Prefers to play alone ☐ No ☐ Yes

Has difficulty making friends ☐ No ☐ Yes

How does your child function in peer groups (e.g., cooperates, is aggressive, avoids groups, parallel plays, etc.)? _____

**Recreation/Interests**

What are your child's favorite toys or objects?

1. _____ 2. _____

3. _____ 4. _____

What favorite activities does your child enjoy and how much time per day is spent in each?

1. _____ Time spent? _____

2. _____ Time spent? _____

3. _____ Time spent? _____

Are there items to which your child insists on carrying around with him/her throughout the day? ☐ No ☐ Yes

Please specify: _____

**Behavior/Temperament**

*Please indicate whether this child exhibits any of the following behaviors.*

Is easily overstimulated in play ☐ No ☐ Yes

Has a short attention span ☐ No ☐ Yes

Lacks self-control ☐ No ☐ Yes

Seems overly energetic in play ☐ No ☐ Yes

Seems impulsive ☐ No ☐ Yes

Overreacts when faced with a problem ☐ No ☐ Yes

| | | | | | |
|---|---|---|---|---|---|
| Seems unhappy most of the time | ☐ No | ☐ Yes | Seems uncomfortable meeting new people | ☐ No | ☐ Yes |
| Withholds affection | ☐ No | ☐ Yes | Requires a lot of parental attention | ☐ No | ☐ Yes |
| Hides feelings | ☐ No | ☐ Yes | Has fears | ☐ No | ☐ Yes |

If your child has fears, please describe: _____

What makes your child angry? _____

What makes your child happy? _____

## Strengths & Limitations

What do you enjoy most about your child? _____

What do you find most difficult about raising your child? _____

When is your child at his/her best? _____

When is your child at his/her "worst"? _____

What do you consider your family's greatest strengths? _____

What are current or potential stressors for your family? _____

## Educational History

### Preschool

Does or did your child attend preschool? ☐ No ☐ Yes

At what age? _____ Days per week: _____ Hours per day: _____

School Name: _____ Teacher: _____

Did your child have to be potty trained? ☐ No ☐ Yes

Any problems in preschool? ☐ No ☐ Yes Describe: _____

Does or did your child attend kindergarten? ☐ No ☐ Yes

At what age? _____ Hours per day: _____

School Name: _____ Teacher: _____

Any problems in kindergarten? ☐ No ☐ Yes Describe: _____

Is there anything else that you would like to share about your child and family? _____

**Thank you for your time and information,**

***Dr. Michelle***