

DEVELOPMENTAL HISTORY

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

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

Relation to Child: _____ Language(s) Spoken in Your Home: _____

Birth Weight: ____ lbs. ____ oz. 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:

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_____ Overactive _____ Rigid and Withdrawn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 Skills 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"/> Head Injuries	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Sustained High Fevers	<input type="checkbox"/> Seizures
<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Constipation
<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"/> 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"/> Limited Self Control or <input type="checkbox"/> Displays Self Control
<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

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 attach a copy of the results**, if available, and explain briefly:

What are your child's strengths?

What are your child's challenges or weaknesses?

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? (circle one)
Any issues/concerns within 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: _____

Does your child have an Individualized Education Plan or receiving special education services (i.e. speech/language, resource support, occupational therapy, physical therapy, etc.)? ___Yes ___No
If so, please summarize here and attach a copy:

Does your child have a 504 Plan? ___Yes ___No
If so, please summarize here and attach a copy: _____

Does your child receiving tutoring support? ___Yes ___No
If so, please describe: _____

Please check any of the following concerns for this school year.

- ___ Low Test/Quiz Grades
- ___ Organizational Issues
- ___ Poor Study Skills
- ___ Social Skill Issues
- ___ Low Motivation
- ___ Increased Frustration
- ___ Not Completing Homework
- ___ Separation Issues
- ___ Behavioral Problems
- ___ Attentional Issues
- ___ Low Self-Esteem
- ___ Emotional Issues

Other: _____

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 describe: _____

Thank you for taking the time to complete this form.
All Information provided is **confidential and cannot be released without your specific consent.**