Developmental History Form

Date Form Completed: _____ **Person Completing the Form**: _____
Name and relationship to client

Client's Name: _____ **Sex**: M / F **Date of Birth**: _____

Address: _____
Street City State Zip

Phone Number: _____ **Email Address**: _____

REASONS FOR EVALUATION

Please list the reason(s) the young person is being referred for the evaluation:

1. _____
   _____
2. _____
   _____
3. _____
   _____

When did these problems begin?

What are you goals for this evaluation?

FAMILY INFORMATION

Mother/Guardian Name: _____ Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Father/Guardian Name: _____ Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Parents are:
- ☐ Married
- ☐ Unmarried, Living Together
- ☐ Never Married, Living Together
- ☐ Separated
- ☐ Divorced
- ☐ Mother Deceased
- ☐ Father Deceased

Child lives with:
- ☐ Biological Mother
- ☐ Biological Father
- ☐ Step-parent
- ☐ Adoptive Parent (specify) _____
- ☐ Grandparent
- ☐ Legal Guardian (specify) _____
- ☐ Other (specify) _____

Sibling Information

Name of sibling	Sex	Age	Different Father?	Different Mother?	List any health/behavior/ learning problems	Lives with child?
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N

How well does your child get along with his/her siblings?
☐ Very Well ☐ Good ☐ Average ☐ Fair ☐ Poor

Is English the young person's primary speaking language: ☐ Yes ☐ No

If no, what is the young person's primary language: _____

What is the young person's secondary language: _____

Child Care and Discipline

Who is primarily responsible for the young person's care? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Who is mainly in charge of discipline in the home? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Please describe discipline techniques: _____

_____

FAMILY PSYCHIATRIC HISTORY

CONDITION/DISORDER	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT	AUNT/ UNCLE	OTHER CLOSE RELATIVES
Alcoholism							
Anxiety							
ADHD/ADD							
Autism Spectrum Disorder							
Bipolar Disorder							
Depression							
Epilepsy/Seizure Disorder							
Genetic Condition							
Hospitalized for Emotional Problems							
Intellectual disability							
Jail Time/Incarceration							
Language disorder							
Learning Disability							
Motor or Vocal Tics							
Psychosis or Schizophrenia							
Special Education							
Substance Abuse							
Suicidal Ideation/Attempt							

PREGNANCY AND BIRTH HISTORY

Parental ages when young person was born: Mom _____ Dad _____

Was this pregnancy full term? ☐ **Yes** ☐ **No** If not, how many weeks before or after the expected due date was the baby born? _____ weeks ☐ **BEFORE** ☐ **AFTER** due date

Pregnancy number: 1st, 2nd, 3rd, 4th, other ____ Totals: # of pregnancies _____ # of miscarriages _____

Was this a multiple birth? ☐ **Yes** ☐ **No** ☐ **UK** ; if yes:☐ **Twins** ☐**Triplets** ☐**Quadruplets**

Were the babies identical? ☐ **Yes** ☐ **No** ☐ **UK** (unknown)

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.): _____

Mother's health during pregnancy:

☐ No health problems during pregnancy ☐ Health during pregnancy not known

☐ Poor weight gain
☐ Seizures
☐ Severe nausea {☐ with dehydration}
☐ Infections (Flu, measles, CMV)

☐ High blood pressure
☐ Eclampsia/Toxemia

☐ Other (specify)_____
☐ Rh (blood group) incompatibility

List medications taken during this pregnancy: _____

_____

_____

Did the mother consume more than 2 glasses of alcohol a day during this pregnancy? ☐ Yes ☐ No

Did the mother smoke during pregnancy? ☐ Yes ☐ No

Did the mother consume illegal substances during the pregnancy? ☐ Yes ☐ No

Labor and Delivery:

☐ No problems during labor and delivery ☐ Not known

Please note whether any problems occurred during labor or delivery (☐ all that apply):

☐ Excessive bleeding
☐ Meconium staining
☐ Fever or infection of mother
☐ Placenta previa or abruption
☐ Other (specify): _____
☐ Forceps Used
☐ Umbilical cord around baby's neck
☐ Breathing difficulties of child
☐ Placenta (bag of water) broke more than 1 day before delivery

Baby was born ☐ head first ☐ breech (feet first) ☐ vaginal ☐ Cesarean (Why? _____

Birth weight _____ lbs _____ oz Length _____ in. (if known) Head circumference _____ in. (if known) Apgar Scores (if known): _____ at 1 min _____ at 5 min

Newborn period:

Was the child healthy as a newborn? ☐ **Yes** ☐ **No** If not, please describe the problems and treatment:

_____

_____

Was the child born with any birth defects? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Did the child require treatment in a newborn intensive care unit? ☐ Yes (for _____ days) ☐ No

Did the baby require any special care immediately after birth? ☐ Yes ☐ No

If yes, √ all that apply

☐ Breathing problems (requiring ☐ oxygen ☐ ventilator *(with a tube in windpipe)*
☐ Placement in an incubator
☐ Blood transfusions
☐ Significant muscle weakness or paralysis
☐ Poor muscle tone
☐ Seizures
☐ Feeding difficulties
☐ Excessive sensitivity to noise/stimulation
☐ Jaundice treated with lights
☐ Infection
☐ Surgery (describe): _____

DEVELOPMENTAL HISTORY

Social Development

Did you notice any delays in the young person's social development? ☐ Yes ☐ No

As an infant, did the young person:

Enjoying cuddling? ☐ Yes ☐ No _____

Tend to be fussy/irritable? ☐ Yes ☐ No _____

Make appropriate eye contact? ☐ Yes ☐ No _____

Respond to his/her name? ☐ Yes ☐ No _____

In the first four years of life, were any special problems noted in the following areas?
If yes, please describe below:

Temper Tantrums ☐ Yes ☐ No _____

Separating from parents ☐ Yes ☐ No _____

Excessive crying ☐ Yes ☐ No _____

Playing with other children ☐ Yes ☐ No _____

Speech and Language Development

Did you notice any delays in the young person's language development? ☐ Yes ☐ No
If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

Show interest in sound *(by 3 months)* ☐ Yes ☐ No _____

Babbling *(by 4 to 6 months)* ☐ Yes ☐ No _____

Understanding words *(by 6-11 months)* ☐ Yes ☐ No _____

Speaking first words *(by 12 months)* ☐ Yes ☐ No _____

Speaking in short phrases *(by 24 months)* ☐ Yes ☐ No _____

Motor Development

Did you notice any delays in the young person's motor development? ☐ Yes ☐ No

If yes, please specify: _____

Did the following milestones develop on time? *Please specify age (year/month).*

Turn over (by 6 months) ☐ Yes ☐ No _____

Sit alone (by 9-12 months) ☐ Yes ☐ No _____

Crawl (by 9-12months) ☐ Yes ☐ No _____

Stand alone (by 9-12 months) ☐ Yes ☐ No _____

Walk alone (by 12-18 months) ☐ Yes ☐ No _____

Walk upstairs (by 36 months) ☐ Yes ☐ No _____

Walk downstairs (by 48 months) ☐ Yes ☐ No _____

Running ☐ Yes ☐ No _____

Which hand does the young person use for writing or drawing? ☐ Right ☐ Left ☐ Both

Eating? ☐ Right ☐ Left ☐ Both

Throwing? ☐ Right ☐ Left ☐ Both

Daily Living

When was the young person toilet trained? Days: _____ Nights:_____

Did bed-wetting occur after toilet training? ☐ Yes ☐ No If yes, until what age? _____

Did bed-soiling occur after toilet training? ☐ Yes ☐ No If yes, until what age? _____

Does your child have difficulty with sensory processing?

If yes, please describe below:

Tolerating Food Textures ☐ Yes ☐ No _____

Gagging or Vomiting ☐ Yes ☐ No _____

Tolerating Clothing ☐ Yes ☐ No _____

Tolerating Touch from Others ☐ Yes ☐ No _____

Does Not Notice Pain ☐ Yes ☐ No _____

Other _____

Significant <u>LOSS</u> of an acquired skill or skills (not just a delay)? For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning ☐ Age of loss: _____ months; Explain: _____

_____

Speech / language ☐ Age of loss: _____ months; Explain: _____

_____

Problem solving ☐ Age of loss: _____ months; Explain: _____

_____

Motor coordination ☐ Age of loss: _____ months; Explain: _____

_____

Bladder/bowel control ☐ Age of loss: _____ months; Explain: _____

_____

MEDICAL HISTORY

☐ No serious illnesses or injuries in the **past** ☐ No serious illnesses or injuries **now**

Date	Age	Diagnosis/Illness	Past	No	Date	Age	Diagnosis/Illness	Past	No
		Serious Injuries	☐	☐			**Lung/breathing Problems**	☐	☐
		Serious head injury	☐	☐			Asthma	☐	☐
		Other serious injury	☐	☐			Pneumonia	☐	☐
		Loss of consciousness	☐	☐			Apnea or irregular breathing	☐	☐
		Sleep Problems	☐	☐			Other: _____	☐	☐
		Neurological Problems	☐	☐			**Stomach/bowel Problems**	☐	☐
		Birth abnormality	☐	☐			Swallowing problems	☐	☐
		Seizures (any type)	☐	☐			Gastroesphageal reflux	☐	☐
		Other: _____					Chronic abdominal pain	☐	☐
		Vision Problem	☐	☐			Chronic diarrhea	☐	☐
		Vision problems at birth	☐	☐			Chronic constipation	☐	☐
		Requires glasses/contacts	☐	☐			Other: _____	☐	☐
		Other: _____	☐	☐			**Kidney/Bladder Problems**	☐	☐
		Hearing Problem	☐	☐			Abnormalities at birth	☐	☐
		Hearing problems at birth	☐	☐			Kidney/bladder infections	☐	☐
		Deafness	☐	☐			Other: _____	☐	☐
		Chronic ear infections	☐	☐			**Muscle/bone/joint) Problems**		
		Ear tubes	☐	☐			Abnormalities at birth	☐	☐

		Other: _____	☐	☐			Scoliosis or spinal curvature	☐	☐
Date	Age	**Diagnosis/Illness**	**Past**	**No**	**Date**	Age	**Diagnosis/Illness**	**Past**	**No**
		Dental Problem	☐	☐			**Circulatory Problem**	☐	☐
		Abnormally shaped/ missing teeth	☐	☐			Anemia	☐	☐
		Extractions/cavities	☐	☐			Sickle cell disease	☐	☐
		Dental braces	☐	☐			Chronic low platelet count	☐	☐
		Other: _____	☐	☐			Bleeding /bruising problem	☐	☐
		Skin Problem	☐	☐			Other: _____	☐	☐
		Eczema	☐	☐			**Hormone Problem**	☐	☐
		Ash leaf patches	☐	☐			Sugar diabetes	☐	☐
		Café-au-lait spots	☐	☐			Early puberty	☐	☐
		Other: _____	☐	☐			Late or incomplete puberty	☐	☐
		Growth Problem	☐	☐			Other: _____	☐	☐
		Failure to gain weight	☐	☐			**Mental Health problem**	☐	☐
		Obesity	☐	☐			ADHD	☐	☐
		Short stature	☐	☐			Oppositional defiant disorder	☐	☐
		Tall stature	☐	☐			Anxiety disorder	☐	☐
		Other: _____	☐	☐			Obsessive-compulsive disorder	☐	☐
		Heart Problem	☐	☐			Depression	☐	☐
		Heart abnormalities at birth	☐	☐			Bipolar disorder (manic-depressive)	☐	☐
		Heart surgery	☐	☐			Schizophrenia	☐	☐
		Heart rhythm abnormalities	☐	☐			Tic disorder (e.g., Tourette)	☐	☐
		High blood pressure	☐	☐			Intellectual disability	☐	☐
		Other: _____	☐	☐			Eating disorder (e.g., anorexia)	☐	☐
							Other: _____	☐	☐

I have confirmed with my child's Primary Care MD that his/her immunizations are up to date. ☐ **Yes** ☐ **No**
If no, explain:_____

Specialized neurological or genetic tests:

☐ No neurological or genetic testing has been done

□ If done	Date (if known) Month/Year	Test	Normal Result	Abnormal Result	Unknown Result
☐		EEG (brain wave test)	☐	☐	☐
☐		CT scan	☐	☐	☐
☐		MRI scan	☐	☐	☐
☐		PET/SPECT/ scan	☐	☐	☐
☐		Other scan (specify):	☐	☐	☐
☐		Chromosomal microarray	☐	☐	☐
☐		Chromosomal analysis (karyotype)	☐	☐	☐
☐		DNA testing for fragile X syndrome	☐	☐	☐
☐		Other genetic test:	☐	☐	☐

List all hospitalizations and surgeries for the young person, include overnight stays (medical or behavioral)

☐ No past hospitalizations or surgery

Reason for hospitalization/surgery	Age	Length of stay

Allergies (to medications, foods, environmental antigens, etc.)

☐ No past or current allergies

Source (medication, food, etc.)	Nature of reaction (hives, trouble breathing, etc.)

Current Medications

☐ No medications taken **now** ☐ Medications are being taken now, but the names are not known

Medication	Dosage	Age at start	Reason for medication	Improved	
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N

Name of person prescribing the medications: _____

RESOURCES: Please indicate resources/services being received **now**

☐ No resources/services are being received now
☐ Early Intervention Services (Agency:_____)
☐ Speech/Language therapy ☐ Psychiatry services ☐ Behavioral therapy ☐ Group therapy ☐ Physical therapy
☐ Occupational therapy ☐ Case management ☐ Wraparound services (WRAP) ☐ Mobile Therapist (MT)
☐ Behavior Specialist Consultant (BSC) ☐ Therapeutic Staff Support (TSS) ☐ Other: _____

EDUCATIONAL HISTORY

School name: _____ Phone:_____

Grade in school: _____ (ever repeat a grade? Yes / No) Teacher (or best contact): _____

Is the young person currently on a formal education plan in school? ☐ **Yes** ☐ **No**

If yes, please check: □ IEP □ 504 Plan

What best describes the young person's current educational program?

Full time in a regular class	☐
Time split between regular and special education classes	☐
Special education class	☐
Aide/Paraprofessional or extra help	☐
Specialized school	☐
Home schooled	☐

Please indicate the educational program in which the young person participated during his/her school* years:

School Year	**Type of School**		**Type of Class**		*Any Special Services*		
	Regular*	Special	Regular*	Special*	Yes	No	Type
3-5 preschool							
Kindergarten							
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							
11th							
12th							

*** REGULAR school applies to public or private schools for children without disabilities.**
SPECIAL school applies to any schools intended for children with disabilities

SOCIAL AND BEHAVIORAL FUNCTIONING

Peer Relationships
Please indicate how the young person relates to peers:

☐ Has problems relating to other children
☐ Has difficulty making friends
☐ Fights frequently with peers
☐ Prefers playing with younger children
☐ Prefers playing with older children

☐ Prefers to play alone
☐ Has a best friend

What role does the young person take in peer groups? ☐ Leader ☐ Follower ☐ Some of Each

How many friends does the young person have? _____

Recreational Interests
What does the young person enjoy?

☐ Sports _____

☐ Hobbies_____

☐ Other _____

What are the young person's personal strengths?

What do you enjoy most about the young person?

What are your hopes for the young person's future?