DEVELOPMENTAL AND HEALTH HISTORY INFORMATION

Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_

Parent(s) Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_Highest Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s) Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_Highest Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Family history can often be helpful in understanding a child’s problems.

**Please check any box that applies:**

|  |  |  |  |
| --- | --- | --- | --- |
| *Has anyone in the family had:* | *Siblings* | *Parents* | *Extended Family* |
| Motor problems? |  |  |  |
| Reading problems? |  |  |  |
| Speech/language problems? |  |  |  |
| School/learning problems? |  |  |  |
| Alcohol/drug problems? |  |  |  |
| Anxiety, depression, other psychological disorders? |  |  |  |
| Seizures/epilepsy? |  |  |  |
| Attention problems/hyperactivity? |  |  |  |

Please list all family members (in or out of house) and other people currently in the house:

**NAME RELATIONSHIP AGE CURRENTLY IN HOUSE?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Parents are: \_\_\_Married \_\_\_Living together \_\_\_Divorced \_\_\_Separated \_\_\_Widowed

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**BIRTH HISTORY:**

Was the pregnancy normal? YES NO

Was the labor and delivery normal? YES NO

(If no to either above, please describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full term? YES NO

(If premature, how many weeks early\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

During pregnancy with this child, did the mother:

Drink alcohol? YES NO Take any drugs? YES NO

Smoke cigarettes? YES NO Take any medications? YES NO

(If yes, list medications taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

During hospital stay, did baby have any problems? YES NO

(If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Were there any problems in the first year of life? YES NO

(If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**DEVELOPMENTAL HISTORY:**

How old was the child when s(he):

Approximate Age (If not sure, please estimate)

Sat? \_\_\_\_\_\_\_\_\_\_\_\_\_ Early Average Late

Walked? \_\_\_\_\_\_\_\_\_\_\_\_\_ Early Average Late

Toilet trained? \_\_\_\_\_\_\_\_\_\_\_\_\_ Early Average Late

Said first words? \_\_\_\_\_\_\_\_\_\_\_\_\_ Early Average Late

Began using sentences? \_\_\_\_\_\_\_\_\_\_\_\_\_ Early Average Late

During the first twelve months, was this child:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | YES | NO |
| Difficult to get to sleep? |  |  | Irritable? |  |  |
| Difficult to put on a schedule? |  |  | Alert? |  |  |
| Easy to comfort? |  |  | Affectionate? |  |  |
| Overactive/in constant motion? |  |  | Sociable? |  |  |

**SPEECH AND LANGUAGE**

Has his/her hearing ever been tested? YES NO

Last hearing/audiology evaluation: PLACE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESULTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this child have a history of frequent ear infections? YES NO

Has s(he) ever had tubes places in her/his ears? YES NO

Does this child have:

Any speech problems/difficulty speaking? YES NO

Have trouble understanding what is being said to him/her? YES NO

Has (s)he ever had a Speech and Language Evaluation? YES NO

(If yes, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

RESULTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has (s)he ever had Speech/Language therapy? YES NO

If (s)he currently receiving Speech/Language Therapy? YES NO

(If yes, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**MOTOR SKILLS**

Does this child have fine motor problems (writing, drawing)? YES NO

Has (s)he ever had an Occupational therapy (OT) evaluation? YES NO

(If yes, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

RESULTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is (s)he currently receiving OT services? YES NO

(If yes, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Does (s)he have any gross motor problems (walking, running)? YES NO

Has (s)he ever had a Physical Therapy (PT) evaluation? YES NO

(If yes, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

RESULTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is)s)he currently receiving PT services? YES NO

(If yes, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Does this child use any adaptive devices (braces)? YES NO

(If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**VISION**

Has this child ever been to an eye doctor? YES NO Most recent date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this child wear glasses? YES NO

(if yes, why\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**MEDICAL HISTORY & CURRENT MEDICAL**

Is this child generally in good health? YES NO

(If no, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Does this child have allergies? YES NO (If yes, to what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Is (s)he currently taking any medications? YES NO

If yes, name of medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did this child ever have a head injury or concussion? YES NO

Has (s)he ever had a high lead level or lead poisoning? YES NO

Does (s)he have a seizure disorder? YES NO

Has this child ever had any serious illness or hospitalization? YES NO

(If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Does this child see any medical specialists (neurologists)? YES NO

If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCHOOL HISTORY**

Name of school / day care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of school\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has (s)he ever repeated a grade? YES NO If yes, which grade(s)?\_\_\_\_\_\_\_\_\_\_\_\_

Is there an Ed. Plan (IEP)? YES NO

Has (s)he ever received special/extra help in school? YES NO

Is (s)he currently receiving special/extra help in school? YES NO

Is yes, please circle types of services being received:

Occupational Therapy Resource Room Speech/Language Reading

Physical Therapy In-class LD Adaptive Phys. Wd Counseling

Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has (s)he ever had a developmental, psychological, or educational evaluation? YES NO

(including school CORE evals)

If yes where was the most recent?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR ASSESSMENT**

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

**BEHAVIOR/MENTAL HEALTH**

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age? (Please put a check in front of any that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Often touchy/easily annoyed |  | Often bullies/threatens |  | Often irritable |
|  | Often defies adult rules |  | Initiates physical fights |  | Changes in appetite |
|  | Often angry/resentful |  | Ever been arrested |  | Diminished interest |
|  | Often argues with adults |  | Physically cruel to others |  | Sleep problems |
|  | Often loses temper |  | Cruel to animals |  | Restlessness or slowed down |
|  | Blames others for mistakes |  | Difficulty maintaining friendships |  | Feels worthless |
|  | Deliberately annoys |  | Destroys property |  | Becomes tearful easily |
|  | Often spiteful/vindictive |  | Deliberately sets fires |  | Often sad |
|  | Refuses to go to school |  | Lies often |  | Indecisive/can’t think |
|  | Repeated nightmares |  | Steals |  | Thinks about death |
|  | Unusual fears |  | Has run away |  | Talks about suicide |
|  | Panic attacks |  | Extreme mood swings |  | Hurt self |
|  | Self-conscious/clings |  | Does not show emotions |  | Currently uses drugs |
|  | Excessive need for reassurance |  | Overreacts to touch/noise |  | Used drugs in the past |
|  | Somatic complaints (headaches, stomach) |  | Strange or bizarre ideas |  | Currently drinks beer or alcohol |
|  | Worry of future events |  | Gets upset by changes in routine |  | Used beer or alcohol in past |
|  | Repeats certain actions |  | Poor social interactions |  | Excessive preoccupation with objects or ideas |
|  | Can’t stop thinking about things |  | Self-injurious behavior |  |  |
|  | Motor or vocal tics |  |  |  |  |