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DEVELOPMENTAL HISTORY FORM

Please complete this form to provide background information for your child's evaluation.

Child's name: _____ Date of Birth: _____

Name of person completing this form:_____

Address: _____

Phone: _____ Child's School: _____ Grade: _____

Child's primary language:_____ Child's secondary language:_____

EARLY DEVELOPMENT/ HEALTH

Length of pregnancy: _____ weeks Birth weight: _____ lbs _____ oz

Was there was anything unusual about your pregnancy? (such as medical concerns or drug or alcohol use) If you answered "Yes," please describe: No

Was there was anything unusual about your delivery? (such as Caesarean delivery, breech birth, forceps used) If you answered "Yes," please describe: No

Did your child reach developmental milestones at normal ages (such as walking and talking)? If you answered "No," please describe: Yes

Please list any significant illness, injuries or medical problems or surgeries your child has had and the ages those occurred.

Is your child taking medication regularly? If so, please list the medication(s).

FAMILY HISTORY

Please list the child's parents, brothers and sisters and anyone else living with the family:

Name	Age	Occupation/ grade in school

How does your child get along with their family?

Have there been any separations, divorce or remarriages? No
If yes, please describe (i.e. child's age and adjustment):

Has the child experienced any significant trauma or abuse? No
If yes, please describe (i.e. child's age and reaction):

Please list any family history of learning problems or mental health concerns (such as attention problems, depression, anxiety, and learning disorders):

LEARNING

Please describe your impression of your child's skills in the following areas (we can talk in more depth when we meet):

Math:_____

Reading:_____

Writing:_____

Foreign Language (if applicable): _____

Study Skills: _____

Please check if your child has had any of the following:

- ☐ Difficulty concentrating
- ☐ Forgetfulness
- ☐ Poor follow through (like on homework)
- ☐ Difficulty staying seated
- ☐ Interrupting
- ☐ Excessive talking
- ☐ Difficulty completing tests on time
- ☐ Irritability or agitation
- ☐ Lack of interest in things that were once interesting
- ☐ Low self-esteem
- ☐ Trouble getting along with family
- ☐ Problems with aggression
- ☐ Sleep problems
- ☐ Bedwetting
- ☐ Sensory sensitivity (such as to noise, bright lights, touch, taste and/or smell)
- ☐ Physical symptoms that aren't explainable
- ☐ Thoughts of hurting self
- ☐ A mental health diagnosis (specify):
- ☐ Losing things
- ☐ Disorganization
- ☐ Trouble listening
- ☐ Impulsive behavior
- ☐ Fidgeting
- ☐ Making careless errors
- ☐ Poor grades
- ☐ Feelings of anxiety or fear
- ☐ Depressed mood
- ☐ Lying
- ☐ Communication problems
- ☐ Social problems
- ☐ Appetite problems
- ☐ Attempts to diet or control eating
- ☐ Excessively high or low energy
- ☐ Use of alcohol or drugs
- ☐ Auditory or visual hallucinations
- ☐ Thoughts of hurting others

How long have these concerns existed?

What has been tried to help with these concerns? Has anything been helpful?

STRENGTHS AND RESILIENCY

What are your child's strengths?

What activities does your child enjoy?

What do you hope to gain from participating in an evaluation?

I appreciate you completing this form. We can talk more about the information in this form when we meet in person. I would be happy to answer any questions you may have. I look forward to working together to support your child. Please feel free to add any additional information: