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DEVELOPMENTAL HISTORY

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

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

Relation to Child: _____ Language 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: _____

_____

Was your child breast-fed? Yes No If so, when weaned? _____
Was your child bottle-fed? Yes No If so, when weaned? _____

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
_____ Irritable/Fussy
_____ Overactive
_____ Frequently Smiled
_____ Difficult to Comfort
_____ Lethargic
_____ Quiet/Complacent
_____ Rigid and Withdrawn
_____ Frequently Cried
_____ Easily Adapted to New Situations

During early childhood, please indicate if your child displayed any of the following behaviors:

_____ Eating Difficulties
_____ Separation Anxiety
_____ Excessive Crying
_____ Sleep Difficulties
_____ Unusual Fears/Anxieties
_____ Thumb Sucking
_____ Temper Tantrums
_____ Nightmares
_____ Social Skill 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 you child has experienced or has been diagnosed with any of the following:

_____ Ear Infections
_____ Head Injuries
_____ Sustained High Fevers
_____ Loss of Consciousness
_____ Diabetes
_____ Lead Poisoning
_____ Lyme Disease
_____ Developmental Delays
_____ Vision Difficulties
_____ Migraine Headaches
_____ Seizures
_____ Constipation
_____ Asthma
_____ Attention-Deficit/Hyperactivity Disorder
_____ Learning Disabilities
_____ 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?

_____ Leader or _____ Follower
_____ Limited Self Control or _____ Displays Self Control
_____ Independent or _____ Dependent
_____ Friendly or _____ Disagreeable
_____ Attentive or _____ Inattentive
_____ Follows Directions or _____ Does Not Follow Directions
_____ Confident or _____ 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 explain _____

_____

What are your child's strengths? _____

What are your child's 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? _____ Any issues/concerns with 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: _____

Is your child receiving special education services (i.e. speech/language, occupational therapy, physical therapy, etc.)? Yes No

If so, please specify: _____

Does your child have a 504 Plan? Yes No If so, please explain: _____

Does your child receiving tutoring support? Yes No If so, please explain: _____

Please check off all items that your child is presently struggling with at school this 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

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 explain: _____

_____

_____

Thank you for taking the time to complete this form. All Information will be kept strictly **confidential**.