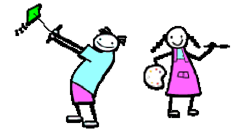
Center for Psychological and Educational Assessment



Comprehensive Evaluations for Children

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⋄ Autism Spectrum ⋄ Learning Disabilities ⋄ Attention Difficulties ⋄ Speech & Language Assessment ⋄ Occupational Therapy ⋄

Child Developmental History Record

A. Identification

1. Child's name: ______________________________________ Birthdate: ________ Age: ____Grade____
Person(s) completing this form: ___________________________________ Today's date: _______________
Relation to child ____

Please describe your current concerns about your child

____
____
____
____

How long have you had these concerns?

____

2. Please list the names and relations of people who currently live with the child
Name ____________________________________ Relation to child ______________________________
Name ____________________________________ Relation to child ______________________________
Name ____________________________________ Relation to child_______________________________
Name ____________________________________ Relation to child ______________________________
Name ____________________________________ Relation to child_______________________________

3. Mother's name: _____________________________ Birthdate:____________ Home phone: ____________

Address: ___________________________City_________State_____Zip_________Email_________________

Currently employed: **No** **Yes** as: ___________________________ Cell phone: _________________________

4. Father's name: _____________________________ Birthdate: _____________ Home phone: ____________

Address: ___________________________City_________State_____Zip_________Email_________________

Currently employed: **No** **Yes** as: ________________________________ Cell phone: ___________________

Party responsible for bill ____________________________ Social Security #___________________________

5. Parents are currently ˜ **Married** ˜ **Divorced** ˜ **Remarried** ˜ **Never married** ˜ Other: _______________

Child's legal custodian/guardian is: ____

6. Please list the child's siblings and their ages:

____
____
____

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B. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery
Any prenatal (before birth) problems? ____
____
____
Was the child premature? ____________ Weight and height at birth: ____________ ____________
Any birth complications or problems?
____
____
____

2. The first few months of life
Breast-fed?__________ If so, for how long?__________
Any allergies? ____

Please list any problems during infancy
____
____
____

3. Milestones: At what age did this child do each of these?
Sit without support: ____________________ Crawl:____________________
Walk without holding on: ____________________ Help when being dressed: ____________
Eat with a fork:____________________ Stay dry all day:____________________
Didn't soil his/her pants: ____________________ Stay dry all night: ____________________
Dress self completely: ____________________

4. Speech/language development
Age when child said first word understandable to strangers: ____________________
Age when child said first sentence understandable to strangers: ____________________
Any speech, hearing, or language difficulties? ____
____
____

C. Health
List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

Please list all **current** medications the child is taking.

Name of medication	Time child took last dosage	Dosage prescribed	How many times per day

Please list **past** medications child has taken previously.
____
____

D. Behavior

Please list any concerns you have about your child's behavior.

____

____

____

How does your child get along with peers?

____

____

How does your child get along with siblings?

____

____

Are there any stressful events occurring in the family that may be affecting your child?

____

To your knowledge, has your child ever been abused or neglected?

____

Is there anyone in the child's family that has ever had:	Family member(s):
Learning Difficulties ______________________	______________________
Attentional Problems ______________________	______________________
Emotional Difficulties ______________________	______________________
Diagnosed Disorder(s) ______________________	______________________
Alcohol or Drug problems, ______________________	______________________
Their own history of abuse______________________	______________________

Please list any **current** intervention your child is receiving (Speech, OT, PT, psychotherapy).

From	To	Description of treatment/Provider's name	Diagnosis

Please list any **past** treatment for your child (Speech, OT, PT, psychotherapy).

From	To	Description of treatment/Provider's name	Diagnosis

Please list any past **evaluations** for your child (Speech, OT, PT, Psychological), and the provider's name

____

____

E. Schools/Learning

Please list all schools child has attended	Grade	Age	Concerns

Does your child currently receive any special education services? ________________________________

If so, what is your child's classification ____

How often does your child receive services? ____

Has your child ever received any special services in the past? ___________________________________

Does (did) your child have any problems learning letters/numbers? _______________________________

Does he/she confuse the sounds in words when speaking?______________________________________

Can your child rhyme words? ____

Describe his/her handwriting. Is it a problem? ____

Can your child follow one step directions? Two step directions? _________________________________

____

Does your child appear to use vocabulary that is age-appropriate? ________________________________

Describe his/her oral expression (uses 1-2 words, full sentences)________________________________

____

Behavior questions:

Does your child…

a. cuddle like other children? ____
b. look at you when you are talking or playing? ___________________________
c. smile in response to a smile from others? _________________________________
d. engage in reciprocal, back-and-forth play? ________________________________
e. play simple imitation games, such as pat-a-cake or peek-a boo? _____________
f. show interest in other children? ____

a. point with his or her finger? ____
b. gesture (e.g., nod yes and no)? ____
c. direct your attention by holding up objects for you to see? ___________________
d. show things to people? ____
e. give inconsistent response to his or her name (or to commands)? ____________
f. use rote, repetitive, or echolalic speech? __________________________________
g. memorize strings of words or scripts? ____________________________________

a. have repetitive, stereotyped, or odd motor behavior? ________________
b. have preoccupations or a narrow range of interests? ________________
c. attend more to parts of an object (e.g., the wheels of a toy car)? _____________
d. have limited or absent pretend play? _____________________________________
e. Imitate other people's actions (e.g. wave bye-bye, play patty cake?)____________
f. play with toys in the same exact way every time? __________________________
g. appear strongly attached to a specific unusual object(s)? ___________________

Does your child seem sensitive to….

a. touch (tags, clothing, touch by others)? ___________________________________
b. noise (puts hands over hears, becomes very distracted)?____________________
c. foods (textures, tastes, temperatures)? ___________________________________
d. smells (highly sensitive to faint smells or smells objects)?___________________
e. movement (does not like swings, somersaults, etc.)?_______________________
f. changes in routine (cannot transition, becomes upset)?_____________________
g. activity (tires easily, props self when playing/sitting)?______________________

Please list your child's play interests, toy preferences, and any special talents.

____
____
____

What things do you and your child enjoy doing together?

____
____

How do you let your child know when you are happy with his/her behavior?

____
____

What methods do you use for discipline?

____
____

G. Other

Please list any other information that you think is important with regard to your child.

____
____

Name of child's pediatrician/primary care doctor____

Would you like a copy of any assessment results sent to the doctor? **Yes** **No**

Please tell us how you found out about the Center for Psychological and Educational Assessment

____

If you are interested in receiving periodic emails about our upcoming programs, please list your email address

____