54 South Avenue
Marietta, GA 30060

770.352.9952
info@atlantachildpsych.com

Center for Psychological and Educational Assessment

DEVELOPMENTAL HISTORY

Identification

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? _____

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_____

Mother's name:_____Birthdate:_____Home phone: _____

Address:_____City_____State_____Zip_____Email_____

Currently employed: ☐**No** ☐**Yes** Occupation:_____Cell phone: _____

Father's name:_____Birthdate:_____Home phone: _____

Address:_____City_____State_____Zip_____Email_____

Currently employed: ☐**No** ☐**Yes** Occupation:_____Cell phone: _____

Parents are currently ☐**Married** ☐**Divorced** ☐**Remarried** ☐**Never married** ☐Other: _____

Child's legal custodian/guardian is: _____

If separated, when did separation occur?_____

Living/visitation arrangements?_____

Please list the child's siblings and their ages:

_____

_____

_____

Development

Pregnancy and delivery

Any prenatal (before birth) problems_____

_____

_____

Medication taken during pregnancy_____

Was the child premature?_____If so, born at_____weeks Weight at birth: _____

Any birth complications or problems?

_____

_____

_____

The first few months of life: Breast-fed?_____If so, for how long?_____

Any allergies? _____

Please list any problems during infancy

_____

_____

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: _____

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? _____

_____

_____

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 (babbles, uses 1-2 words, full sentences)_____

Health

List all childhood illnesses, **chronic ear infections**, 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:

Medication	Date initially prescribed	Time child took last dose	Dosage prescribed	How many times per day?

Please list **past** medications child has taken:

Any difficulties with sleep? _____

Problems with eating/appetite? _____

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?

Does (or did when younger) your child… (check any that apply)

- ☐ cuddle like other children?
- ☐ look at you when you are talking or playing?
- ☐ smile when others smile at him/her?
- ☐ engage in reciprocal, back-and-forth play?
- ☐ play simple imitation games, such as pat-a-cake or peek-a boo?
- ☐ show interest in other children?
- ☐ point with his or her finger?
- ☐ gesture (e.g., nod yes and no)?
- ☐ direct your attention by holding up objects for you to see?
- ☐ show things to people?
- ☐ give inconsistent response to his or her name (or to commands)?
- ☐ use rote, repetitive, or echolalic speech?
- ☐ memorize strings of words or scripts?
- ☐ have repetitive or odd motor behavior (hand flapping, toe walking)?
- ☐ have preoccupations or a narrow range of interests?
- ☐ attend more to parts of an object (e.g., the wheels of a toy car)?
- ☐ demonstrate pretend play (not imitated from TV/movies)?
- ☐ imitate other people's actions (e.g. wave bye-bye, play patty cake?)
- ☐ play with toys in the same exact way every time?
- ☐ appear strongly attached to a specific unusual object(s)?

Does (or did) your child seem sensitive to…. (check any that apply)

- ☐ touch (tags, clothing, touch by others)?
- ☐ noise (puts hands over hears, becomes very distracted)?
- ☐ foods (textures, tastes, temperatures)?
- ☐ smells (highly sensitive to faint smells or smells objects)?
- ☐ movement (does not like swings, somersaults, etc.)?
- ☐ changes in routine (cannot transition, becomes upset)?
- ☐ activity (tires easily, props self when playing/sitting)?

Please elaborate on any of the above behaviors if needed: _____

_____

_____

Evaluation/Intervention

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_____ _____

Any previous diagnoses for your child? ☐**No** ☐**Yes** If yes:

Diagnosis	Age	Diagnosis by whom?	Was any testing completed?

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

Dates: From/To	Description of treatment/Provider's name	Diagnosis

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

Dates: From/To	Description of treatment/Provider's name	Diagnosis

Please list any past **evaluations** for your child (Speech, OT, PT, Psychological, Educational/School):

Dates:	Type of evaluation	Provider Name	Diagnosis

Schools/Learning

Please list all schools child has attended:	Grade	Age	Concerns

Grades repeated_____

Does your child currently receive any EIP or special education services? ☐**Special Education** ☐**EIP**

If special education, what is the eligibility area(s): (Learning Disability, Autism, Other Health Impaired, etc.)

How often/in what subject areas does your child receive services?_____

Has your child ever received any special services or EIP in the **past**?_____

Any tutoring? If so:

Subjects/skills	Age	Provider

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?_____

Please list your child's play interests, toy preferences, and any special talents. What do they choose to play with during unstructured times? Do they enjoy a variety of toys, or play with the same toys repeatedly?

_____
_____
_____

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?

_____
_____

Other

Name of child's pediatrician/primary care doctor_____
Would you like a copy of any assessment results sent to the doctor? ☐**No** ☐**Yes**

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

_____

Any other information that you feel is important, or questions you would like answered through assessment:

_____
_____

This is a strictly confidential patient medical record.