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

Any vision/hearing difficulties? _____

Approximate date of last hearing and vision testing: _____

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):

- | | |
|---|-------|
| <input type="checkbox"/> Learning Difficulties _____ | _____ |
| <input type="checkbox"/> Attentional Problems _____ | _____ |
| <input type="checkbox"/> Emotional Difficulties _____ | _____ |
| <input type="checkbox"/> Diagnosed Disorder(s) _____ | _____ |
| <input type="checkbox"/> Alcohol or Drug problems _____ | _____ |
| <input type="checkbox"/> Their own history of abuse _____ | _____ |

Any previous diagnoses for your child? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes:	Was any
Diagnosis	Age	Diagnosis by whom?	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.