Developmental History Information

I. Student Information:

Student Name:_____DOB: ____/____/____ Grade:_____
Address _____ Phone Number _____
Teacher:_____ School:_____
Parent(s)/ Guardian:_____

II. Family Information:

What are your child's strengths?_____
_____

What concerns do you have for your child?_____
_____

In what language did your child first learn to talk?_____
If English is 2nd language, how long has your child spoken English?_____
What language is primarily spoken at home?_____
Major Life Events Experienced by Your Child:

☐Divorce of Parents ☐Death of a Close Family Member ☐Major Illness
☐Home Dislocation ☐Home Fire ☐Natural Disaster

Is there any other major life event experienced by your child that you think may have had an impact on your child?_____

III. Medical History:

Child's physician_____ Physician phone #_____
Check any of the following complications that occurred during the pregnancy:

☐Toxemia ☐Gestational Diabetes ☐Measles ☐RH incompatibility
☐Alcohol ☐Tobacco ☐Low Oxygen ☐Premature Birth
☐Other_____

Has this child ever had any serious illnesses, accidents, or head injuries? ☐Yes ☐No
If "yes", please explain:_____

Has this child ever experienced problems in the following areas?

☐walking ☐temper tantrums ☐underweight/ overweight ☐unclear speech ☐failure to thrive
☐hearing ☐vision ☐sleep problems ☐eating problems ☐does not speak
☐fine motor skills (handwriting, tying shoes, etc) ☐Difficulty making friends
☐gross motor skills (running, riding bike, skip, etc) ☐Other
If any of the above are checked please specify:_____
_____

Please indicate any illness this child has experienced:

☐Measles ☐Mumps ☐Asthma ☐Frequent Ear Infections ☐Gastro-intestinal problems
☐Diphtheria ☐Seizures ☐Rheumatic fever ☐Loss of consciousness ☐Any heart condition
☐Meningitis ☐Allergies ☐Verbal/ motor tics ☐Other, please describe:_____

Is this child presently on any medications? ☐Yes ☐No
If "yes", what kind?_____

Has your child ever had psychological counseling or therapy? ☐Yes ☐No
Complete the following if "Yes": Counselor's Name:_____ Phone:_____

Has this child ever had a neurological exam? ☐Yes ☐No
If "Yes", please specify:_____

IV. Educational Background:
Did this child attend preschool? ☐Yes ☐No
If "Yes", where and for how long?_____

Have any relatives had difficulties similar to those this child is experiencing? ☐Yes ☐No
If "Yes", please explain: _____

Please indicate whether this child exhibits any of the following behavior:
☐Has a short attention span ☐ Has Fears ☐Overreacts when faced with a problem
☐Unhappy much of the time ☐Seems impulsive ☐Requires a lot of attention
☐Enjoys active games ☐Enjoys activities such as reading, drawing, writing, etc.
☐ Needs more help with school work than others his/her age
Other: _____

Pleas indicate any of the following that this student has experienced in school:
☐Skipped a grade ☐Disliked going to school ☐Had frequent absences from school
☐Behavior problems ☐Emotional difficulties ☐Changed schools several times in one school year
☐Poor Grades ☐Difficulty with Math ☐Has been evaluated for special education
☐Been Retained ☐Difficulty with Reading ☐Difficulty with writing or spelling
Other:_____

V. Social History:
How does your child spend his/her free time?_____
_____

How may close friends does your child have? ☐0-2 ☐2-4 ☐4 or more

Please indicate if your child is able to do the following [now or earlier in their development]:
☐Show good eye contact ☐engage in pretend play ☐Discuss a variety of interests
☐Initiate conversation ☐initiate play ☐Is able to adjust to changes in routine

I give permission for my child to be observed, as needed, by educational specialists (speech-language pathologists, school psychologists, hearing specialist, etc.)

Signature of person completing this form:_____

Relationship to the student:_____

Please return this form to:_____